

Psychiatry in Society

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Preface

Some time ago one of us wrote that social psychiatry will disappear and that it is likely that ''the world will be a slightly better place without it'' [1]. The reason for this statement was that it is unimaginable that psychiatry could be practised or that psychiatric research could be conducted without constant reference to social factors and to the social environment. It was agreed that it is therefore unnecessary to have social psychiatry as a special discipline—all psychiatry being also social—but it is also harmful to use this term because the existence of social psychiatry could be taken as a proof that good psychiatry can exist without its social component.

The changes of the social context affect the incidence and prevalence of mental disorders, their course and outcome, and their reaction to treatment. Social changes are also of determinant importance for the rehabilitation of people who had mental illness. They affect, furthermore, the organization of health care, the training of health care staff, and the willingness and capacity of families to look after their sick members.

This volume brings together 11 contributions, each of which deals with the interaction between psychiatry and a particular set of social factors. Thus, Eisenberg explores the impact of medical ideology on psychiatric care; Häfner's chapter examines the influence of changes in health care systems on mental health care; Bertolote *et al*., Okasha, and Lewis and Araya, respectively, examine the legal, ethical and economic contexts of care and their influence on psychiatry. Mass media and psychiatry are examined in Cuenca's chapter; the impact of disasters in Bromet and Havenaar's text; Saraceno *et al*., Kovess, and Bebbington *et al*. deal with the special social circumstances under which care is or should be provided. There are numerous indicators of the manner in which social environments and psychiatry interact; of those, quality of life has been selected for detailed examination because it is the most relevant outcome of the interaction between social contexts and care for people with mental illness, and Katschnig and Krautgartner's chapter addresses that issue.

There are many other areas on the interface between social development and psychiatry which will not be covered by this volume; this is the unavoidable consequence of limitation of space and time allotted for the production of the volume. Two among those omissions, however, deserve special mention. The first of them—stigma and discrimination because of mental illness—is at present the most important obstacle to the provision of

care for people with mental illness. Several national programmes to combat stigma have been started recently (e.g., in Australia, Sweden, and the UK) and the World Psychiatric Association (WPA) has launched a major multi-site programme to deal with stigma because of schizophrenia. The results from these programmes have begun to emerge and their presentation will be given a special place in the scientific programme of the next World Congress of Psychiatry in Yokohama, Japan, in 2002. Similarly, the practice of psychiatry under conditions of extreme financial scarcity has been selected as an institutional programme of the WPA and will be a focal point for presentation during the Yokohama Congress. Chapters addressing those two areas of interest will thus be among those that will follow the Yokohama meeting.

We hope that the materials assembled in this volume will stimulate and facilitate discussion about social factors and psychiatry. The World Bank has recently begun publishing materials and reports about the economic and social importance of mental illness; it would be deplorable to see psychiatrists absent from this type of debate and from the social arena within which psychiatry is firmly rooted and on which it depends in so many of its aspects.

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REFERENCE

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CHAPTER

1

The Impact of Sociocultural and Economic Changes on Psychiatry

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INTRODUCTION

The distribution of health and disease in human populations reflects where people live, how they live, what they eat, the work they do, the air they breathe and the water they drink, their interconnectedness with others, the beliefs they hold about health and disease, and the organization and quality of health care available to them. The status they occupy in the social order determines their risk for disease, on the one hand, and their access to care, on the other. What they believe guides what they choose from among the options available to them. Because all human disease is social, changed social conditions alter the epidemiology and course of disease.

Among the cultural factors influencing health care is the culture of medicine: the conventional wisdom taught to physicians that guides the actions they carry out. Part of the mystique of medical culture is the convenient fiction that the practice of medicine is simply the application of science to the treatment of disease. That may be what medicine aims to achieve, but much of daily practice is based on tradition, opinion, anecdote and folklore (for example, what grandmothers ‘‘know’’: that bed rest is good for the sick person).

BELIEF AS A DETERMINANT OF CARE

Paul Beeson [1] compared the treatments recommended in the first (1927) edition of Cecil's [2] *Textbook of Medicine* with those recommended in its fourteenth (1977) edition [3]. Enormous gains in medical knowledge had occurred during that half-century. The new knowledge enabled Beeson to

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rate 60% of the remedies in the first edition as harmful, dubious or at best symptomatic and only 3% as providing fully effective treatment or prevention; by the fourteenth edition, effective regimes had increased sevenfold and dubious ones had decreased by two-thirds. Despite the sevenfold increase, only a fifth of the remedies listed in this widely used textbook were based on evidence sufficient to establish that they were fully effective. Were Beeson's study to be repeated today, further positive shifts in those ratios would be recorded, but many treatments in common use today continue to be based on faith rather than evidence.

To demonstrate the impact of cultural beliefs, medical and lay, on the way care is provided, I begin with three illustrations of widespread medical practices which had not a scintilla of evidence to back them. Yet, they were used universally when my medical career began: sanatorium treatment for tuberculosis; complete bed rest for coronary occlusion; and prolonged hospitalization for psychiatric disorders. All rested on folk belief in the beneficent effects of rest. Then, I turn to diagnostic ''fashions'' in medicine, jointly shaped by doctors and patients in their efforts to account for distress. Finally, I review the complex relationship between socioeconomic status and disease.

The Sanatorium Treatment of Tuberculosis

In 1945, the standard of care for the treatment of tuberculosis was prolonged bed rest in sanatoria. Even though no study had demonstrated its efficacy (and the one done by Stochs and Karn [4] had reported worse outcome than care at home), ''resting the lung'' seemed self-evidently desirable. It seemed logical that (a) diminished motion of the lung favors healing; (b) rest lowers pulmonary circulation and hence results in less diffusion of ''toxins'' from the lung; (c) shorter and fewer respiratory excursions decrease cough and expectoration, limit the spread of purulent discharge and reduce the likelihood of pulmonary hemorrhage [5]. In response to this therapeutic philosophy, the number of sanatorium beds grew from 12 000 in 1908 to 30 000 in 1915, and from 80 000 in 1931 to 100 000 by mid-century.

The first randomized trial in clinical medicine [6] demonstrated the effectiveness of streptomycin in the treatment of tuberculosis. Soon thereafter, *p*-amino-salicylic acid and isoniazid joined a growing list of effective chemotherapeutic agents. Yet, lung specialists continued to insist upon bed rest as the essential ingredient in care. Six years after the definitive streptomycin trial, the Committee on Therapy of the American Trudeau Society warned against calling outpatient treatment ''ambulatory'', lest that term suggest a repudiation of rest therapy. Medication, they insisted, was only a ''supplement'' to the rest treatment provided in a sanatorium. It was not

until 1961, well over a decade after the evidence was in, that the Trudeau Society [7] finally abandoned bed rest as the bedrock of therapy. Although many of the leading figures in the American Tuberculosis Society owned or operated sanatoria (and thus might have caused a conflict of interest), leading specialists with no financial stake were equally convinced that bed rest was essential. The long lag in abandoning a useless (and costly) practice demonstrates the power of entrenched belief.

It was all the easier to believe because of a continuing secular trend toward lower mortality. The US mortality rate from tuberculosis, 113 per 100 000 in 1920, had fallen to 20 by 1950. Better general health and improved nutrition had increased host resistance, public health programs (including isolating infectious patients in sanatoria) and less crowded housing had reduced transmission. Doctors credited their treatments for the health transition accompanying industrialization [8].

Mandatory Bed Rest as the Treatment of Myocardial Infarction

The widespread belief in ''rest'' as a cardinal principle for treating a diseased organ is illustrated by another medical imperative: three to six weeks of complete bed rest for patients with acute coronary thrombosis. The plan was justified on the grounds that rupture of the heart had been observed to occur as long as two weeks after a coronary occlusion and because scar formation, as determined by autopsy data, was not complete for a month or more. There were some skeptics [9–12], but the practice was universal when I started my medical training. Indeed, failure to mandate prolonged bed rest after an infarction was grounds for dismissal from the staff.

Samuel Levine, a distinguished cardiologist at the Peter Bent Brigham Hospital in Boston, questioned the logic of total bed rest [13]. Recumbency, he pointed out, affords less rest to the heart than a sedentary position with the feet down, because it encourages maximal venous return, leads to the pooling of blood in the pulmonary circuit, and augments volume work for the heart. In contrast, the sitting position permits gravity to mobilize fluid into the dependent parts of the body and so lessens cardiac work. Bedridden patients, he noted, are at risk for thrombophlebitis. Furthermore, he added, ''the abruptness of the onset . . . with its grave prognostic implications . . . when coupled with long continued bed rest saps morale, provokes depression, unleashes anxiety and ushers in hopelessness . . . the deleterious physical equivalents of such emotional disquiet and psychological tension, though not measurable, are evident to both the physician and family'' [14].

Levine [15] introduced ''chair treatment''. Patients were encouraged to feed themselves and were either permitted use of a bedside commode or

granted toilet privileges. In his words, "one of the most spectacular features" of the "chair-treated coronaries" was the "enhanced sense of well-being ... the gradually increasing time out of bed provides the patient with the clearest index of improvement. He is made to feel an aware and active participant in the healing process."

The recommendation for chair treatment perturbed the Brigham Hospital's house officers. Levine's junior associate has described his efforts to elicit their cooperation [16]:

> My pleading and arguments generally were to no avail.... When I insisted, some called my attention to the Nuremburg trials.... My tactic was to bring Levine to the bedside.... House staff were as obedient as if they were serving in the military.... Patient recruitment was initially slow and halting ... [but] witnessing even one patient in a chair rapidly won converts.

Nonetheless, it was several decades before early mobilization became standard and hospital stays were substantially shortened. The process was accelerated, first by changes in hospital remuneration patterns (from cost-plus to payment by diagnosis-related group that made shorter stays more rather than less profitable for hospitals) and later by controls on length of stay imposed by managed care organizations. What had been a movement to improve health outcomes became one to improve financial outcomes. Today, in many US hospitals, the protocol for uncomplicated acute myocardial infarction is a four-day maximum inpatient stay [17, 18], a startling change from yesteryear's mandatory three- to six-week regime!

A treatment that incurred high costs, psychological and physiological no less than financial, persisted because of faith in the value of "rest"; its effectiveness had never been put to the test. Challenging the conventional wisdom took considerable courage. Had one or more of the patients in Levine's first series developed a fatal arrhythmia as they were being ambulated, the experiment would have been terminated and the originator shunned.

Prolonged Hospitalization for Mental Illness

The psychiatric analogy to bed rest was prolonged inpatient hospital treatment. When I arrived at the Johns Hopkins University in the early 1950s, the length of the hospital stay was reflected in the protocols designed for the residency training program. The first 30 days of the patient's stay was allocated for a thorough work-up; the house officer was required to prepare a "personal dynamic formulation" (PDF) for presentation at the end of that period. The PDF set forth a comprehensive treatment plan on the expectation that months of inpatient care would follow.

Just as I joined the Johns Hopkins staff, Blue Cross, the principal private insurer in Maryland, agreed for the first time to cover 30 days of psychiatric hospitalization. This occurred at a moment when the Phipps Psychiatric Clinic, like other university units, was facing increasing costs, shrinking returns from endowment, and too few self-pay patients to fill its beds. In response to the new source of reimbursement and the consequent reduction in the length of stay for insured patients, it suddenly became feasible for house officers to prepare a PDF in seven days instead of 30; average length of stay declined sharply.

The 1950s were, of course, the decade in which psychotropic drugs were introduced and the therapeutic community movement reached the USA from the UK. But there is no doubt that the change in funding mechanisms accelerated patient work-ups and reduced inpatient days in a university program where no one had ever paid much attention to the bottom line. To the surprise of many staff members who were wedded to long-term psychodynamic treatment, many patients did quite well. Psychiatrists were as reluctant to give up their ''magic mountain'' as pulmonologists had been.

Changes in Care Change the Course of Disease

Much more had happened than substituting less expensive for more expensive care. Many patients did better (not merely just as well) after early release from the hospital and return to the community. That was particularly true for the patients who had been confined in understaffed and underfinanced state hospitals. The very symptoms that psychiatrists had employed to justify long hospital stays proved to be the result of the hospitalization itself.

In the mid-1950s, the census of public hospitals in the USA peaked at 560 000 inpatients. Linear projections had led to expectations that bed occupancy would exceed 700 000 by 1970 [19]. Instead, the bed census for state and county mental hospital recorded for 1970 had fallen by half; the most recent data (for 1998) are about 63 000 [20]. What had happened and why?

What psychiatrists mistook for the malignant course of schizophrenia itself resulted from the superimposition of institutionalism on the psychopathology of the disease. Locked doors, loss of personal control, regimentation, and unoccupied days of hopeless despair promoted regression; regimentation made robots of patients. Geographic barriers and bureaucratic obstacles to visiting heightened sequestration from family ties. The understaffed ''asylum'' with its locked doors perpetuated social maladaptation and promoted chronicity [21]. Families closed ranks behind patients.

What resulted was "the social breakdown syndrome" [22]. The social psychiatry movement beginning after World War II in the UK with its commitment to the "open hospital" and "community psychiatry" began to halt the chronicity produced by the "total institution" well before psychotropic drugs were in wide use [23, 24], although effective drugs accelerated the rate of change.

Can There Be Too Much of a Good Thing?

But university and non-profit psychiatric hospitals were due for a second hit: in the late 1980s and 1990s, insurance organizations sharply limited the length of the hospital stay they would pay for; the Blue Cross 30-day stay of yore became a romantic image of a halcyon past. The impact can be seen in length of stay (LOS) data I obtained recently from an excellent non-profit psychiatric hospital with an academic affiliation. In 1986, the average LOS was about 73 days, the number of admissions about 1000, and the number of beds 320. By 1992, LOS had been reduced to 30 days, but the hospital endowment was bleeding. By 2000, the beds were half as many, admissions six times higher (yes, 6000!), and LOS 8 days. The hospital balance sheet is still in the red (because third-party payers reimburse at less than full cost) but the rate of loss has been mostly staunched. Data from a second outstanding not-for-profit mental hospital are similar: average LOS in 1990 was 45 days; in 1992, it was 24 days; in 1994–2000, it had dropped to 14–15 days.

If four weeks was better for most patients than 6–12 months, is eight days enough? An eight-day "average" of course includes a spread of individual stays ranging from two days to several months. Some patients are pushed out prematurely because the insurer will not agree to additional days the staff considers necessary; some patients who might profit from a period of respite and planning for community care are denied hospitalization altogether. What is objectionable is a set of rules designed to improve the bottom line rather than to provide optimum care for each patient. Nonetheless, it must be admitted that our profession contributed to the present chaos. We did not undertake the studies that might have provided solid evidence to justify clinical decisions. Because the database is inadequate, treatment philosophy flows from finances rather than having finances determined by patient needs.

Fashions in Treatment

Thus, phthisiologists, cardiologists and psychiatrists designed and carried out treatment programs based on no more than folklore: the belief that rest

restores the body and the mind. This faith persisted, despite a clarion call by an astute clinician almost 60 years ago [9]: ''The physician must almost always consider complete bed rest as a highly unphysiologic and definitely hazardous form of therapy, to be ordered only for specific indications and discontinued as early as possible.'' And it persists today in many areas of medicine. Allen *et al*. [25] reviewed 39 randomized controlled trials on the effect of bed rest on a variety of disorders. In 15 trials of bed rest as primary treatment, *no* outcomes improved significantly and nine worsened. In 24 trials of bed rest after a medical procedure, no outcomes were better and eight were worse. Eighty percent of neurological units in the UK continue to require bed rest after spinal puncture despite the evidence it does not prevent headache.

FASHIONS IN DISEASE NAMES AND PATTERNS

If fashions in treatment are slow to change, this is equally true of the way illness patterns are conceptualized by doctors as well as patients.

As an intern more than 50 years ago, I worked up a 38-year-old man for complaints of weakness, fatigue, low grade fever, migrating aches and pains, and an inconstant rash. By a careful history, I found that he had worked 10 years earlier in a rendering plant where he experienced an acute infection with fever, chills, and myalgia. He recovered after several weeks, but had never felt completely well thereafter. When agglutinin titers came back positive from the laboratory and his skin test for the *Brucella* antigen puffed up, my colleagues and I confidently made the diagnosis of chronic brucellosis from the history and the serology. The patient was pleased to have a name for what was wrong even though we had no specific treatment to offer.

What was wrong with this diagnosis? Serology (and skin tests) remain positive for years after *Brucella* infection, whether or not the patient is symptomatic. Later studies were to show [26] that what distinguishes those with persisting symptoms from those without them is not the agglutinin titer but a depressive disorder which correlates with pre-illness personality and life circumstances. Chronic brucellosis is not a disease, but a pattern of illness behavior, triggered by an acute infection in a psychologically predisposed individual, an illness pattern reinforced by medical labeling that crystallizes distress by sanctioning it as a biological entity.

With chronic brucellosis largely controlled by public health measures, it disappeared from the medical scene in the USA. But it was soon replaced by new idioms of distress: chronic fatigue syndrome [27, 28], fibromyalgia [29, 30], and chronic Lyme disease [31, 32].

Chronic fatigue syndrome (CFS) was initially ascribed to infection with the Epstein-Barr (E-B) virus [33]. Patients did (and do) have high virus titers, but so do most Americans; the virus is ubiquitous! After the E-B virus was abandoned, other causal agents have been proposed; thus far, each has failed of proof [34]. CFS patients suffer an illness as real as any other. What is at issue is its causation and its significance. Despite the overlap in symptoms, CFS is not simply a somatized form of depression [35]; a randomized trial of fluoxetine for CFS did not show benefit—even for those patients with comorbid depression [36]. CFS patients failed to respond to a trial of fludrocortisone acetate [37], a treatment proposed to correct the neurally mediated hypotension common in CFS. Negative trials have left CFS patients in limbo; not only has the treatment failed, but the cause of their illness remains ambiguous. Patients are aggrieved when doctors dismiss their complaints as ''mental'' (i.e., not ''real'') because they can't find a bug or a toxin [38]. Patients have taken the lead in organizing a Chronic Fatigue Syndrome and Immune Deficiency Society to lobby for the legitimacy of their disease. They visit doctors who purvey illusory theories and ''cures'' and profit from their patronage.

Chronic brucellosis and CFS were preceded in the 19th century by neurasthenia [39] and early in the 20th century by effort syndrome and myalgic encephalomyelitis. ''Chronic Lyme disease'' is a new entry on the scene. Like chronic brucellosis, it is an illness syndrome that appears months or years after an episode of acute disease caused, in this case, by infection with the spirochete *Borrelia burgdorferi*. Sufferers attribute the symptoms to the earlier infection; the evidence for this claim is at best equivocal. Seltzer *et al.* [32] reported a long-term study comparing several hundred patients who had suffered an episode of acute Lyme disease and age-matched controls with no history of Lyme disease. Although many former Lyme patients reported increases in symptoms and increased difficulties with daily activities of living during a follow-up of 1–11 years after the diagnosis of Lyme disease, the frequency of symptoms and problems did not differ significantly from those reported by the controls over the same interval. Allen Steere [40], a leading investigator of acute Lyme disease, evaluated 788 patients referred to his clinic for ''chronic Lyme disease'' [41]. Twenty-three percent appeared to be suffering from acute Lyme disease; 20% had Lyme disease plus a concurrent illness (most commonly chronic fatigue syndrome or fibromyalgia); 57% had no Lyme disease at all, but suffered from other fatigue or pain syndromes.

With time, these syndromes will be sorted out in new constellations and will be renamed to fit new explanatory models. One can be certain of two things: that ''new'' somatization syndromes will arise and that new names will be given to them.

A Psychiatric *Folie à Deux*

In the last two decades, in the USA and the UK, there has been a *virtual* epidemic of ''multiple personality disorder'' attributed to ''repressed memories'' of sexual abuse in childhood. More accurately, there has been an epidemic of the diagnosis without any reliable evidence of an epidemic of the disorder. Pierre Janet reported dual consciousness as early as in the 1880s, but the clinical diagnosis of multiple personality disorder remained relatively rare until a case history was described at book length by Thigpen and Cleckley [42]. In the 1970s and 1980s, cases multiplied rapidly; even more strikingly, the number of different ''personalities'' found in individual patients multiplied just as rapidly [43]. By the end of the 1980s, claims reached the hundreds.

The dissociation was attributed to repressed memory of sexual abuse in childhood. ''Therapists'' were able to generate ''memories'' of abuse in the very first year of life despite the impossibility of an infant encoding memory in words before the development of language. With the ''help'' of psychotherapists, patients ''recovered'' memories of having been involved in Satanic sexual orgies and in breeding infants they subsequently cannibalized. Others reported having been abducted by Martian aliens for sexual manipulation. Quite apart from the absence of any confirmatory evidence, it is no less remarkable that many ''memories'' were of patently impossible events (e.g., giving birth at age six). The movement metastasized into the law courts. Patients sued their parents and obtained sizeable settlements in some cases. It was not long before parents began to retaliate by suing the ''therapists'' who had entrapped their children. The damage to families was incalculable [44]. What went on in the USA was repeated in the UK [45].

The repressed memories jointly fabricated by therapists and patients recall an era in 19th century Paris: the flamboyant symptoms displayed by hysterics who were presented by the eminent neurologist Jean-Martin Charcot to packed amphitheaters at the Salpêtrière. On command, patients would display *arc en cercle* (opisthotonos), pseudoseizures, anesthesias and paralyses [46]. The epidemic of grand hysteria gradually subsided and is no longer seen in Paris or elsewhere. Yet, Charcot was no charlatan, but one of the most highly regarded physicians of his time. He led his patients unwittingly into behaving as he expected; their performance met their needs as well as his. Thus, it is less surprising that it was not only unqualified ''therapists'' who participated in the generation of a non-disease; reputable psychiatry departments gave credence to the same ideologic baggage. The farce seems finally to be playing itself out, hoist with its own petard by the need to multiply personalities and to fabricate ever more outlandish ''memories''. The history of this episode should be an embarrassment to psychiatry [47, 48]. It is a ''memory'' we dare not forget.

DOES PROSPERITY IMPLY THE END OF DISEASE?

The recognition that poverty is associated with disease is ancient. As living conditions in the industrialized nations have improved, so has life expectancy at birth—from less than 50 years at the beginning of the 20th century to well over 70 years by its end. Nonetheless, socioeconomic status and health status remain closely correlated. The extent of income inequality within a given population is an even more significant predictor of health status. In a study of the associations between income inequality and mortality in 282 US metropolitan areas, those areas with the greatest income inequalities were found to have death rates far higher than those with narrower extremes. Excess mortality ranged from 64.7 to 95.8 per hundred thousand. Effects were most evident for infant mortality and mortality in the adult years from 15 to 64. To put the magnitude of this mortality difference into perspective, it is comparable to the combined loss of life from lung cancer, diabetes, motor vehicle crashes, human immunodeficiency virus (HIV) infection, suicide and homicide in the USA [49].

Modernization, however, is not a royal road to better health. ''Epidemics'' of diabetes have appeared among Polynesians, American Indians, and Aboriginal Australians as traditional lifestyles have been altered. Consider the population of Nauru, a small Pacific island inhabited by about 5000 Micronesians. Until World War II, high energy expenditure was required for sheer survival through fishing and hardscrabble subsistence farming. After the war, foreign companies began large-scale phosphate mining and paid rental income to the Nauruans, rapidly transforming them into one of the world's wealthiest *and* most sedentary peoples. Today, virtually all foodstuffs are imported; most have a high caloric content; obesity is ubiquitous.

Non-insulin-dependent diabetes mellitus (NIDDM), previously minimal, reached epidemic proportions in the 1950s and afflicted almost two-thirds of 55–64-year-olds. Paradoxically, wealthy Nauru now has one of the world's shortest life spans because of diabetes and its complications [50]. The Nauru epidemic has ominous implications for Southeast Asia. Rates of diabetes among Chinese and Indian expatriates living in the West (in contrast to low rates in China and India) make it virtually certain that the improved living standards anticipated for India and China in the next century will lead to epidemics of NIDDM [51].

Social Class and Mental Disorder

Is there a relationship between mental disorder and poverty? Faris and Dunham [52] demonstrated that rates for mental disorder are higher in

lower-class than in middle-class and upper-class neighborhoods. They reported that high rates of psychosis ''cluster in the deteriorated regions in and surrounding the center of the city, no matter what race or nationality inhabits that region''. They hypothesized that ''extended isolation of the person (a product of the disorganized neighborhood) produces the abnormal traits of behavior and mentality''. However, 30 years later, Dunham [53] undertook a new study which led him to conclude that ''type of community and social class'' have no effect on the incidence of schizophrenia. Rather, the differential rates observed reflect residential mobility arising from social sorting and selection.

The association between disease rate and social class has been repeatedly confirmed. The question remains: to what extent does poverty account for increased rates in low-income areas and to what extent do those increases reflect downward social drift arising from economic and interpersonal incompetence? Conclusive answers are not in. The two hypotheses need not be dichotomous. Further, what is true for one mental disorder may not be true for another. Dohrenwend *et al*. [54] have provided evidence from a careful epidemiologic study in Israel that the aggregation of schizophrenia in poor areas reflects downward drift, whereas the high rates for depression in women, and antisocial personality and substance abuse disorders in men arise from the social stress associated with low socioeconomic status. For both schizophrenia and depression, the course and outcome of the illness are influenced by socioeconomic status, as it affects the likelihood of getting care and the quality of care that is provided.

CONCLUSIONS

Economic and cultural conditions have an important effect on the health status of populations. It is the role of medical science to combat false belief among professionals as well as the laity. In Bertolt Brecht's play *Life of Galileo*, the author has his protagonist say: ''One of the chief causes of poverty in science is imaginary wealth. The purpose of science is not to open the door to an infinitude of wisdom, but to set some limits on the infinitude of error.''

The measures taken to combat disease must be social as well as medical. Inequalities in health and differential access to care by social class plague billions the world over. Those differentials among nations and *within* nations grow worse with each passing year [55]. The implications for health are ominous. In the words of Rudolf Virchow, written a century and a half ago [56]: ''If disease is an expression of individual life under unfavorable conditions, then epidemics must be indicative of mass disturbances of mass life.''

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CHAPTER

2

Changes in Health Care Systems and Their Impact on Mental Health Care

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INTRODUCTION

Health care systems can be defined as ''comprising all the organizations, institutions and resources that are directed to producing health actions. A health action is . . . any effort . . . in personal health care, public health service or through intersectional initiatives (for example, in cooperation with the educational, social or economic system), whose primary purpose is to improve health''[1]. Improving health means to improve people's physical, social and mental well-being [2].

But ''health systems have a responsibility not just to improve people's health, but to protect them against the financial cost of illness—and to treat them with dignity'' [1]. Meeting this objective is the purpose of health systems ''in every country independently of how rich or poor it is'' [1]. ''Poor people . . . need financial protection as much as or more than the well-off, since even small absolute risks may have catastrophic consequences for them. And the poor are just as entitled to respectful treatment as the rich, even if less can be done for them materially''[1].

The goodness of a health care system is measured by the output indicators of the various fields of action or of all health actions taken together, e.g., in terms of changes in the morbidity and mortality of a total population. From the consumers' point of view, Murray and Frenk [3] add a further criterion: health care systems should respond well to people's expectations. This criterion refers to a facet of health care that has grown highly important in today's democratic cultures where the relationship between the providers and consumers of health services is characterized by partnership rather than paternalism.

The aforementioned social objective of health care systems, to protect people against the financial cost of illness, is covered by the traditional tenet of the World Health Organization (WHO) demanding ''health for all''. Murray and Frenk [3] interpret it as the criterion of fairness in financial contribution. Fairness means that the health care system responds equally well to everyone without discrimination. Fairness represents a basic value of a health care system classifiable as a human right. It is practised at the political level and requires the allocation of financial, human and institutional resources without placing any individual or section of a population at a disadvantage.

Daniels *et al.* [4] go still further, subsuming under the criterion of fairness also the quality of the management of a health care system, which the WHO includes in the notion of stewardship: ''Fairness is a many-sided concept, broader than the concept of equity. . . . Fairness includes equity in health outcomes, in access to all forms of care and in financing. Fairness also includes efficiency in management and allocation . . .'' [4]. They continue: ''For the public to have influence over health care, fairness must also include accountability. Finally, fairness also includes appropriate forms of patient and provider autonomy.'' These are important criteria for judging the quality of health care systems in free societies, but they are better defined and discussed separately.

A health care system also includes public health activities such as health promotion and disease prevention. Hence, road and environmental safety, sanitation, protection against epidemics, and food quality control are part of the health care system of a country.

The economic component of health care is a key system aspect. It provides for and limits the material and human resources. The economic component is the most powerful tool of regulating health actions at any level, including the health care system as such. With reference to the cost-effectiveness aspects of health care systems, again, a distinction must be made between the medical system providing treatment, prevention and rehabilitation at the individual level and the cost-effectiveness aspects of health promotion and disease prevention focused on the population as a whole (public health).

The costs of investing in and running a health care system are paid by the consumers using these services, by society as a whole through taxes or by a certain section of society through prepaid contributions. The distribution of the burden of health financing between the government, the working population and individual citizens is a key policy choice in any society. The share in health financing paid by the government and the citizens is conversely related to the utilization of health services.

The objective of any health care system, providing financial protection against the cost of illness, is of special relevance in long-lasting and disabling illness, which is particularly frequent in the mental health field.

According to the WHO, the financial burden of health care should be *fairly* distributed with the aim of having the healthy section of the population, by way of solidarity, share in the costs of illness. From these ideas various systems of national and social health insurance have sprung. In a system of fully socialized health risks the concern for health has been made a basic civil right [5].

Through health insurance, society as a whole or a certain section of it, such as the gainfully employed, can be burdened with the costs of illness and its consequences or the government with the costs of certain health risks. Health insurance can essentially contribute to fairness in a health care system by not excluding those unable to pay their share. This will be discussed in detail later.

THE MENTAL HEALTH CARE SYSTEM AND ITS COMPONENTS

Mental health care should be an integral part of the overall health care system, its curative-medical, disease prevention and health promotion sectors. Many disease prevention programmes, such as obstetric care, the prevention of alcohol abuse and the containment of human immunodeficiency virus (HIV) infection, pursue both physical and mental health objectives. The same also holds for the treatment of frequent mental comorbidity in physical illness and vice versa. "Mental health is a vitally important aspect of public health that has long been segregated and neglected.... It is time to move mental health into the mainstream of health policy and practice" [6]. But this ideal of a closely intertwined physical and mental health care, which I consciously place at the beginning of this chapter, is not yet fully realized nor has it even always been intended in the past.

Recent population surveys have shown that mental disorders are highly prevalent in most countries throughout the world [7, 8]. In low-income countries, for lack of financial and human resources and because of "a very low priority of health-service policy" [9], mental health care is frequently neglected. But even in high-income countries with well-developed health care systems, such as the USA and Canada, "only a minority of mental patients receive adequate (and timely) treatment" (40% in the first year following illness onset) [8], although solid evidence exists that modern therapies are effective in treating the most commonly occurring mental disorders [8, 10]. An important reason for this is a widespread occurrence of delay in first help-seeking for single episodes [8]. The vast majority of recent-onset patients, even those who report substantial impairment associated with their disorder, receive first treatment more than a year and frequently even several years after the onset of the disorder.

Since age of onset of mental illnesses is inversely correlated with the delay in first treatment contact, as shown by the studies of Olfson *et al*. [11] and Kessler *et al*. [12], early-onset illnesses, frequently leading to lifelong disabilities at an early stage, are particularly slow to receive treatment. The Age, Beginning and Course (ABC) Schizophrenia Study [13] showed that in Germany, despite the availability of a tight network of health and mental health services, three-quarters of the cases of schizophrenia have a prodromal phase of an average length of five years and a psychotic prephase of one year before coming in contact with treatment services. It is in this early illness stage before first contact that most of the social consequences of schizophrenia manifest themselves [14].

Lack of knowledge of and negative attitudes of patients and their families towards mental disorders and their treatment facilities essentially contribute, in some countries more than in others, to the considerable delay in seeking help.

For this reason, mental health care means not only to encourage mentally ill people to seek treatment, but also to inform the patients, their relatives and the public about mental disorders and their treatment. The future of mental health care should offer outreach to these patients and improve early recognition of diseases for early treatment, whenever possible, because early intervention has the prospect of reducing early consequences of illness.

Cooperation in and coordination of mental health care actions are frequently indispensable not only between the providers of mental health care, but also with the providers of physical health care. Cooperation in an individual case, e.g., on the medical treatment of the pancreatitis of a person with alcoholism in psychiatric treatment, represents the lowest level of the system aspect. This level already makes plain the necessity for integrating various professions, diagnostic and treatment services in a multiprofessional enterprise comprising different specialities or disciplines. Examples are a large hospital or a network of community mental health services. That kind of multidisciplinary network of health care services, encompassing both preventive and rehabilitative components, is primarily aimed at maintaining and restoring the health of individuals.

The public health components of mental health care systems encompass multidisciplinary health promotive and disease preventive actions. As examples we can mention perinatal care and the prevention of AIDS, both associated with serious physical and mental health risks. Further determinants of mental health are the overall living conditions, including nutrition, education and safety. ''Improving social conditions will inevitably improve the mental health status of a community,'' Gureje and Alem [9] state, writing about the living conditions extremely unfavourable for mental health in some African countries. ''Wars and internecine strife disrupt social

and community life and spread hunger, disease, and homelessness. These disruptions lead to psychological disorders'' [9].

In many countries preventive health actions are not executed in cooperation with or by the mental health care system, but are taken autonomously within other sectors, such as the social services, the educational system or the field of agriculture.

WHO IS RESPONSIBLE FOR THE HEALTH CARE OF A NATION?

The History of Ideas of Health Care Systems

Mental health care systems frequently show characteristics that cannot be explained either by the current evidence for particular modes of treatment and care or the present economic state of a country. ''Mental health services systems are typically shaped by historical tradition, political decisions and conventions of practice, financing and organization'', Moscarelli and Rupp [15] write in their editorial to a special issue on mental health care. To be able to understand the role of these factors in mental health care systems, it is necessary to make a short excursion into the history of the social and political ideas and the economic conditions that have moulded health and mental health care systems.

Behind the current expectation that the state should bear responsibility for providing health care and compensation for the costs of illness and its consequences of any type there lies a long history of ideas. That history can be condensed into the answers to the question: what can governments do for the health of the people? In highly developed cultures it was early realized that there are health risks that only communities can successfully fight against as well as health risks that threaten the whole population [16]. Thriving economies like the medieval Mediterranean city states or 17th century England became aware of the fact that ''the toll of illness and death meant great losses in productivity'' [1].

The first attempts at translating these ideas into public action were preventive in nature: measures, such as quarantine, usually taken by port cities to protect their citizens by preventing epidemics from being brought in by ships' crews, rats and passengers. The reduction of food-related risks, as by meat inspection and garbage removal, has long, but very different traditions in the leading cultures around the world.

Decisive improvement in the health of most nations, reflected in continued reductions in infant mortality and increases in life expectancy, began to occur in the second half of the 19th century. The progress was triggered by the detection of asepsis and by research results in the field of

medical epidemiology. Especially in Great Britain and Germany it was demonstrated how social conditions and infectious diseases such as tuberculosis and cholera were related. The four major risk factors mediating the association between social conditions and morbidity and premature mortality were poor nutrition, poor sanitation, and poor living and working conditions.

A decisive step was the discovery of the way some of these diseases spread—drinking water polluted with sewage—by the British physician John Snow during the cholera epidemics of 1849, 1852 and 1853 in London. This epochal insight, followed in the subsequent decades by the discovery of the infectious agent and the ways of transmission of other major contagious diseases—tuberculosis, smallpox and diphtheria—and finally by active immunization against smallpox, unleashed in many countries enormous investments in the protection of drinking water, sanitation, garbage removal and nutritional hygiene.

The pace was almost breathtaking at which somatic medicine acquired numerous highly potent means of immunizing against and treating diseases. Well into the 20th century remarkable improvement in public health occurred in those countries that could afford protective public health measures and a fully developed health care system. With the advances in hygiene and medical science, the whole range of diseases changed: the classic epidemics and along with them the most frequent infectious diseases played an ever diminishing role in the morbidity spectrum of high-income countries. They were superseded by non-infectious, complex health risks particularly in the mental health domain, chronic diseases and behaviour-related health risks [17].

Until the present day the triumphant progress in physical medicine has been uninterrupted, challenged only recently by the emergence of new, unknown infectious diseases, such as AIDS, and the return of old epidemics, such as malaria and tuberculosis. At the same time, the number of physicians has increased rapidly and health expenditures have exploded in rich countries and also in some medium-income and developing countries.

In high-income countries health systems have grown into large economic complexes, devouring large proportions of national expenditures, on average 8–15% of the gross domestic product (GDP). In many countries they have become important, if not the main, providers of work.

It was probably the French social and state philosophers of the 18th century that had the greatest impact on making citizens' health and wellbeing a major duty of the state. As early as the late 17th century, Abbé Claude Fleury, tutor of Louis XIV's grandsons, proclaimed: ''The main duty of the state is to preserve the health and morals of its citizens, to encourage population growth and prevent disease and crime'' (cited by Sand [18]).

Similar ideas are to be found in the works of Rousseau, Voltaire and Beaumarchais. They deem the state responsible for the health, morals and well-being of its citizens in a comprehensive way. In 1748, in his *De l'esprit des lois*, Montesquieu wrote that the state should take care of the welfare of orphans, the ill and the elderly, but he also added that in a democratic state the citizens should also themselves contribute to a healthy living by education and self-education [19].

With the victory of the bourgeoisie, the French Revolution helped to spread the ideas of freedom, equality and fraternity in the population at large. Given the plight of the workers and their families in the early industrial age, the labour movement began to call for the state to step in as a compensator for the financial risk of illness. It is in this tradition, reflected in a series of resolutions of the United Nations (UN) and the WHO after World War II, that the social dimension of today's health and social insurance systems, under the earlier mentioned goal of fairness, is rooted. In continuance of this history of ideas there exist today the tax-financed national health care systems and state-run or state-controlled health and social insurance systems. They reflect the duty of the state to take care of its citizens by maintaining their well-being and health and by covering the economic consequences of ill-health.

The Liberal, State-Independent Tradition of Health Care

While the central-European tradition placed on the state the responsibility for providing socially and economically just health care, the early British political philosophers took a different, utilitarian approach. According to Nehemiah Grew's memorandum of 1707, the government had the duty to promote health and population growth, but merely in the interest of the nation. Sickness and death were regarded as leading to a loss of economic and national power and, thus, as public liabilities. The government was called on to preserve the health of its citizens, in order to increase the labour force and recruits for the army and in this way to enhance Britain's riches and power. This goal required first and foremost cheap labour. It was Joseph Priestley (1773–1804) who finally declared that the government should be released from the responsibility for the well-being and health of its citizens, because people, left on their own, would be capable of taking care of themselves and able to improve their living conditions from day to day. Thanks to this radical liberalism the riches and power of the British Empire grew, and the old, paternalistic ideal of solidarity and welfare fell into oblivion.

Originating in the belief in the blessings of relentless pursuit of self-interest, the extreme forms of liberalism and capitalism practised in Great

Britain were increasingly suffering from their own consequences: growing social distress, destitution of the working class, and epidemics and high mortality rates in the centres of merciless industrialization. For a long time, state action in the health care field was limited to providing rudimentary health and social care for the poor. It was not until a total change of system occurred, with the introduction of the National Health Service in 1948, that this tradition of radical liberalism came to an end in Great Britain.

The ideology of unlimited liberalism has survived in the USA, although not without undergoing several small-scale reforms. Almost 75% of the US population have to pay for the treatment and consequences of ill health out of their pocket or by prepaid fees to private insurance schemes. The government insurance schemes, such as the Veterans Administration, Medicare and Medicaid, provide—mostly only partial—health benefits to limited sections of the population, such as former service personnel, the elderly and the poor. Vast groups at risk, especially the chronically mentally ill, go unprotected with a risk of financial and social ruin in case of severe continued illness.

In the past two decades, with the aim of controlling or reducing costs in this, the world's most expensive health care system, a managed care system with private-enterprise health maintenance organizations (HMOs) was established in the USA. The HMOs, which make contracts with employers, physicians, hospitals and other health services, provide comprehensive health benefit plans for the employees of large companies and also of individual states. This market-oriented system, which has led to serious problems in mental health care—we will come back to them later—has become a model for a stepwise reform of the health care system in many countries and for bringing private-enterprise elements into state-run or solidarity-based health care systems.

Against the background of this brief history of ideas, we are today faced with two competing, though increasingly reciprocally influenced, value orientations in the existing health care systems. The one holds that the government alone is responsible for providing health and social care, according to the principle of fairness, as well as protection against the financial risk of ill health for the entire population. The other is the liberal tradition according to which state involvement in the health care sector should be kept to a minimum and individuals should pay for their health costs themselves. In the former case, health services are financed and run by government or private organizations, or by both; in the latter, health services are provided mostly by private enterprises, and large proportions of the population are left without adequate coverage.

Because of its basic incompatibility with the humanitarian and social values as expressed in the resolutions of various international organizations

(UN, European Union, etc.) as well as with the criterion of fairness as advocated by the WHO, the radically liberal tradition, especially as it does without a proper system of social care, has undergone some small-scale reforms. Nevertheless, the ideal of citizens' independence and a deep dislike of any form of governmental patronage, even with respect to health risks, are still widespread in the USA:

> America is a land of individuals rather than cooperators, of unrepentant capitalists, of rugged entrepreneurs who get on by their own gumption or are left behind as failures. Americans are not without private generosity for those who fall by the wayside (so long as they are deemed worthy); but they dislike institutionalized generosity (epitomized by the old welfare system) that saps a man's will to heave himself up. [20]

THE PUBLIC-HEALTH RELEVANCE OF MENTAL DISORDERS

One issue of mental health care, as important in the past as at present, was already mentioned as one of the reasons why mental illness is not always treated adequately or it is treated with a delay. According to Pirisi [21],

> mental illness has sat on the back burner around the globe in terms of medical and public attention and resources. . . . [That] has kept mental illness from getting its due recognition as a costly, disabling form of disease. . . . Social stigma has been foremost in contributing to the long silence that has kept mental illness locked away in asylums, and harboured as dirty family secrets not to be mentioned to neighbours or employers.

For this reason, the enormous public health relevance of mental disorders did not receive the attention it deserved for a long time.

It is also one of the reasons why psychiatry was comparatively late to develop into a scientific and therapeutic discipline and why the integration of mental health care in the general health care system has been slow in almost all countries.

The widespread ignorance of the high frequency of mental disorders and of their social and economic implications was not overcome until transnationally comparable population surveys were conducted in different countries and progress was made in assessing life years lost through disability [7]. According to the *World Health Report 1999* [22], neuropsychiatric conditions make up an estimated 11.5% of the global burden of disease. They globally account for 28% of the total years lived in disability (except for sub-Saharan Africa where they account for 16%). A large proportion of the burden of disease is attributable to major depression, also linked to

increased mortality by making up the majority of about 800 000 suicides per year [21, 22]. Wells *et al*. [23] "have shown that the effects of major depression . . . on . . . quality of life outcome are comparable to, and in some respects greater than, the effects of such chronic physical disorders as hypertension, diabetes and arthritis, to name but a few" [8]. Due to their low age of onset and chronicity, severe mental disorders frequently have "powerful adverse effects on critical life course transitions, such as educational attainment, teenage childbearing [24], and marital instability and violence [25]" [8]. These facts indisputably show the necessity for any society to provide for a mental health care system quantitatively and qualitatively of the same standard as the general health care system.

Most mental disorders differ from most physical diseases in their ratio of cure and care not only quantitatively, but also qualitatively. In many physical diseases inpatient care is closely associated with medical treatment both temporally and functionally and is usually provided at the same location, such as a hospital. But this is only rarely the case with mental disorders and disabilities. Just consider dementia, a frequent disorder of old age: instead of inpatient treatment, rarely necessary, long-term support in activities of daily living and, at more advanced stages of the illness, comprehensive care are needed. Consider the social disabilities and occupational impairment of chronic schizophrenic patients, and the need for psychosocial training, and social and occupational rehabilitation becomes evident. In chronic schizophrenia, the need for psychosocial care, if available, exceeds that for inpatient and outpatient medical care to a considerable extent. A similar pattern of need can also exist in some physical diseases, but clearly more rarely.

"The universe of mental health is vast and multidimensional," says Üstün [6]. Given its psychosocial dimension, the universe of mental health care clearly exceeds that of general health care. To accomplish its tasks, a mental health care system at any rate must offer not only medical and psychiatric, but also a wide range of psychosocial services. Psychosocial care and occupational rehabilitation are in part provided by the mental health care system alone, mostly, however, in cooperation or competition with the existing social services.

In this context, the contribution of families, especially in the case of the socially disabled chronically ill, must be borne in mind. Particularly in countries with predominantly extended families, family care plays an important role. When adequate social care systems are lacking, families are more or less compelled to care for their ill members irrespective of whether they are capable of doing so or not. Hence, an essential indicator of the goodness of a mental health system is whether and to what extent the needs of the chronically mentally ill and disabled for non-medical and social care are met.

FAIRNESS IN HEALTH CARE: HOW TO PROTECT AGAINST THE FINANCIAL RISK OF ILL HEALTH

The requirement of fairness in national health care systems was fulfilled very late and in only a few countries. For most people in any country, ''until well into the 19th century . . . little protection from financial risk [existed] apart from that offered by charity or by [the described] small-scale pooling of contributions among workers in the same occupation'' [1].

The early forms of mental health care, knowledge of the nature of illnesses and their prevention and treatment, as well as the systems of protecting against financial risks, did not evolve homogeneously. On the basis of their observations of workers in silver mines, the Swiss physician Paracelsus as early as 1535 and later, in 1614, Martin Pansa in Germany described acute quicksilver intoxications and chronic heavy-metal encephalopathies and proposed preventive security measures. Reports of the fates of affected miners, their widows and orphaned children gave rise to the formation of the first miners' societies based on the principle of solidarity. Their aim was to help all disabled miners and their families. In this way small-scale systems sprang up out of a feeling of solidarity fairly early to provide protection against the financial risk of ill health and its consequences. These core systems, founded in Europe in the 19th century in other occupations as well, were the forerunners of the modern solidarity-based health insurance systems.

Towards the end of the 19th century, the time was ripe for first steps towards the establishment of health and social security systems. In 1883 the German chancellor Bismarck enacted a law requiring employer contributions to health benefits for low-wage workers in certain occupations, adding other classes of workers in subsequent years. The contributions to this preliminary, state-mandated social insurance scheme, which covered illness costs first for employees, and later also for their families, were shared by employers and employees. The benefits that these laws brought to the working class and the step that it took towards establishing social justice led to the adoption of similar legislation in Belgium in 1894, in Norway in 1909 and later in many other industrialized countries. After World War I the German model also began to spread outside Europe, to Japan, Chile, etc. [1, 5].

An alternative model, a state-run health service, was first established in Russia in the late 19th century, when a huge network of provincial medical stations, local dispensaries and hospitals were founded to offer treatment free of charge. The system was financed from tax funds. After the Russian Revolution in 1917, free medical care was provided for the entire population in a completely centralized and state-controlled system.

In 1948 Britain, as already mentioned, replaced its mostly private health insurance system, which left a large proportion of the mostly poorer section of the population unprotected against the financial risk, by the National Health Service. Previously, New Zealand had introduced a similar system in 1938. The 1944 British government's White Paper stated the policy as follows: ''Everybody irrespective of means, age, sex or occupation shall have equal opportunity to benefit from the best and most up to date medical and allied services available . . . those services should be comprehensive and free of charge and should promote good health as well as treating sickness and disease'' [1]. Many other countries, such as the Scandinavian, followed suit.

''In a third model state involvement is more limited . . . sometimes providing coverage only for the most under-privileged population groups in giving way for the rest of the populace to largely private finance, provision and ownership of facilities'' [1]. This is the case in some high-income countries, such as the USA, and naturally also in many medium- and low-income countries that lack the resources to finance health care for their entire population. As a result, deficits in fairness are widespread. In many of the poorest countries only a few rich people can afford to pay for their health care costs, while the majority cannot.

In the last two decades the question of which of these systems is the best and least expensive, was discussed with great intensity and controversy. Due to soaring health costs and increasing economic constraints in the late 20th century, economic aspects moved to the foreground. Health expenditures can be more easily controlled in tax-funded state-run health care systems. However, the advantage of achieving a maximum balance between rich and poor, ill and healthy, in protecting against the financial risk and the advantage of an optimal regulation of health care are diminished by the fact that such systems discourage the initiative of the health care personnel and, as a result, lead to a low efficiency at the micro-level [5]. Frequent consequences are as follows: (a) reduced productivity and quality of health services; (b) rationing of cost-intensive services (e.g., surgery), usually to the disadvantage of certain at-risk groups (e.g., the elderly, people with diabetes, and the mentally ill, a further at-risk group, but apparently not in the British national health service—whether and to what extent the mentally ill are disadvantaged, is primarily a question of a political decision in a centralized health care system); (c) lengthy waiting lists; (d) limited autonomy of users to choose physicians and hospitals; and (e) growing dissatisfaction among users [5].

Contribution-based systems have the advantage that both employers and employees pay their share. In these systems, usually also family members are insured and the financial costs of ill health and disability are covered. Their innate weakness is that only the working population makes a financial

contribution. In countries with declining working populations and increasing numbers of the elderly and the unemployed with greater needs for health care, these systems are pushed to the limits of their financial capacity. In this context the World Bank speaks of from-hand-to-mouth systems that will inevitably lead to intergenerational conflict [5].

Table 2.1 shows three basic systems that have been adopted to provide protection against the financial risk of ill health. The state-managed, centralist type of a national health care system is divided into a socialist type, currently under reform in many countries to make it more democratic, and a democratic type, such as the National Health Service of Great Britain. In addition, there are various private (or mixed) systems of health insurance and health care.

Private health care systems based on either direct payment or private insurance place the less well-off sections of the population at a disadvantage. Governments aiming at fairness in their social policy actions are compelled to find ways of financing health care from tax funds for certain underprivileged groups. Such government subsidies, as in the USA and Switzerland, enhance fairness.

In many countries, mental health care—as far as it consists of the therapy traditionally supplied by psychiatrists and medical services, as in private practice or the hospital—has been included, step by step, in the benefits provided by state-run or contribution-based systems. Where this is the case, there has been—and still is—a tendency to exclude from coverage—or set temporal limits to the coverage of—expensive long-term care for chronic psychiatric disorders involving multisectoral services. This will be discussed in greater detail in the context of managed care.

Another problem of health-insurance systems rather specific to mental health care has been the financing of long-term care of the disabled mentally ill either in institutions or in the community. Most health-insurance systems cover only treatment costs, but not social and occupational rehabilitation or long-term care for disability, which in many cultures is traditionally the duty of families. In some high-income countries where coverage was expanded in periods of economic growth, a considerable proportion of the costs of utilizing the services for the disabled has been financed by the social security system.

But the mentally ill are still at risk of being disadvantaged compared with the physically ill. For example, in Germany, until 1980, 50% of the costs of inpatient care in a mental hospital had to be paid by the patients themselves or their families, provided they were not incapable of doing so and thus eligible for tax-funded welfare. In most low-income countries, mental patients in need of treatment and their families receive no financial support to pay for treatment and to cover the loss of income during illness- or disability-related incapacity to work. The only coverage the mentally ill in many of

Table 2.1 Mental health care systems and their structure. From Schneider [5], modified

	Financed by	Controlled by	Insurance provided by	Services provided by	Users
Centralist national health care systems					
Socialist health care system	State	State	State	State hospitals and clinics	Users assigned to services
National health service	State	State	State	State hospitals Specialists General practitioners	Users enrolled
Contribution (solidarity)-based insurance schemes—only health insurance					
Social (solidarity-based) insurance scheme	Employers Employees	State controlled: – hospitals – physicians in private practice – health insurance organizations	Mandatory health insurance Organizations under state control	Hospitals Physicians in private practice, etc.	Free choice of physicians
Private (mixed) systems comprising only health insurance or health insurance and managed care					
Managed care system	Employers State Users	HMOs	HMOs	Hospitals Physicians Laboratories, etc.	Users enrolled
Private insurance schemes	Users	Hospitals Physicians Health insurance organizations	Health insurance organizations	Hospitals Physicians, etc.	Free choice of physicians

HMOs: health maintenance organizations. Reproduced by permission.

these countries receive is limited to inpatient treatment in state mental hospitals, of which usually very few exist. Until recently, the costs of treating alcohol and drug abuse and related health risks were excluded from coverage in some countries, because these conditions were regarded as self-inflicted and, hence, as the patient's own responsibility.

THE HISTORY OF MENTAL HEALTH CARE

From the Confinement of Socially Intolerable Behaviour in Asylums to Health Care for the Mentally Ill

Over long periods of time in the past, mental health care merely comprised the care provided for the chronically mentally ill and disabled. Until the mid 20th century, effective therapies for chronic or acute mental disorders were almost non-existent. In addition, there was a fundamental lack of knowledge of the causes and underlying pathophysiological processes of mental disorders, which raised doubts about their disease nature and, hence, the eligibility of the mentally ill for the benefits provided by the general health care system.

''In the 16th century paupers and lunatics were generally classed with vagrants and disorderly persons and treated in the same way, since madness meant socially intolerable behaviour'' [26]. The authorities responded by erecting asylums or prisons, where mentally ill persons were confined together with criminals, vagrants and other socially intolerable persons in most large European cities. The role of physicians was limited to treating the inmates for physical illness, and this was also the case in lunatic asylums well into the 19th century.

The early stages of mental health care are marked by charitable initiatives mostly run by large religious communities. Long before the mental-asylum movement reached its peak in the 19th century, infirmaries were founded in a number of countries—for example, Egypt, Spain, England, and Hesse, Germany—to provide residential care for ''innocent'' lunatics and the physically infirm. The Bethlem and Royal Hospital in London was founded in 1247 and the asylum at Valencia in Spain in 1409. In these institutions incurably ill or disabled persons could live under bearable conditions that were preferable to life in freedom at the mercy of wars, famines and epidemics.

The principles of the bourgeois society of the early modern age that underlay these protosystems of mental health care were to provide charity to those in need of help, and to control and confine socially intolerable behaviour. The socio-historical interpretation prefers the latter set of motives. The French philosopher Michel Foucault [27], for example, regarded the entire system of mental health care as ''the great imprisonment of

madness'' serving the conservative middle classes and the bureaucracy of the authoritarian central government in post-Napoleonic France. According to Foucault, the aim was to stabilize the existing social order and political system by labelling, controlling and excluding from society the unruly insane.

In the latter half of the 20th century, several authors expounded similar antipsychiatric ideologies [28–31]. Presenting different politico-historical or sociological arguments, they accused the mental health care system of labelling, controlling, oppressing and exploiting the mentally ill. Meanwhile, their teachings, which seemed to have some plausibility in view of the early forms of custodial care provided by large, remote mental hospitals, have all been refuted by the evolution of psychiatry into a therapeutic discipline and by the emergence of a modern humanitarian system of mental health care.

The Advent of Civil Rights

In the 19th century, mental health care consisted of the long-term treatment of lunatics in mostly closed institutions and of the treatment of the less severely ill by physicians in private practice. In the late 19th and the early 20th centuries, several fashionable therapies attracted large numbers of mental patients suffering from non-psychotic illness, including Mesmer's suggestive electromagnetic therapy, Coué's autosuggestion therapy and various forms of hypnosis therapy. In addition, sedatives and other phytogenic preparations existed. Clearly potent therapies, apart from suggestive effects, however, were available to doctors neither in private practice, nor in the hospital.

Most of the few asylums admitting mental patients were run like prisons. Agitated patients were calmed by applying such methods, hardly less than torture, as straitjackets and, later, extended hot baths. In the absence of effective therapies, psychotic patients were subdued by mechanical restraint.

The ideas of the Enlightenment that spread in the wake of the French Revolution triggered a change in the way society dealt with its mentally ill members. The most prominent event marking the paradigm shift from the repression and exclusion of socially intolerable behaviour to a humanitarian approach was demonstrated by Philippe Pinel's liberation of 49 lunatics from their chains in the Hôpital Bicêtre, Paris, in 1793. By this act the human dignity of severely mentally ill persons was acknowledged. Pinel described how previously highly agitated, violent patients, after they had been unchained, behaved quite normally and unaggressively when treated as equals. This experience was of decisive importance for the rise of modern

mental health care. It first became reflected in the no-restraint movement that spread from Britain all over the world. Its tenet was to limit the use of force in mental health care to the absolute minimum necessary.

The Introduction of the Sick Role and the Birth of Mental Health Care

According to D.H. Tuke, the British pioneer of the no-restraint movement [32],

> Pinel introduced a new philosophy of mental health care. By this act . . . born of the spirit of the French Revolution and symbolic of a new attitude to the insane Pinel abolished brutal repression and replaced it by a humanitarian medical approach, which in the mid-19th century culminated in the great English no-restraint movement and which made possible psychiatry as it is known today.

Besides the change in society's attitude, Tuke mentions as a factor leading to the liberation of the mentally ill another fundamental paradigm of mental health care that Pinel [33] had also stressed: ''These people should not be treated as guilty but as sick deserving all the kindness that we owe to suffering human beings.''

This meant that the mentally ill were given the same measure of compassion and help that the bourgeois society in those days was obliged to offer to its sick members. But that was not much. Mentally ill persons continued to be locked away in asylums, which in some countries were given more pleasant names; for instance, in Germany they were now called institutions for curing and caring for the mentally ill. Knowledge of what caused mental illnesses and how to treat them effectively did not exist.

As abnormal behaviour was seen as illness, society's response changed and mental health care was born. Physicians were put in charge of treating the mentally ill. In 1818 Heinroth was appointed to the first chair of psychiatry, in Leipzig, Germany. Further chairs followed soon in France, other countries of central and western Europe, Russia and the USA, and in the 20th century in most countries around the world. These developments paved the way for the convergence of mental health and general health care systems at least on the academic level. But the asylums were still far from being integrated in the general health care system.

Idealism in Psychiatry: Curing Mental Illness by Education

In the mid-19th century, psychiatry was seized by idealism. The German philosopher Immanuel Kant had already taught that underlying mental

illness was a disordered reason that could only be cured by philosophers, not physicians. The leading proponent of this idealistic pedagogical school was the Heidelberg psychiatrist C.F.W. Roller, who taught that the disordered mind resulted from a lack of education and moral order in the family and environment. Roller [34] concluded that the mentally ill should be isolated from their purportedly pathogenic environment: ''All mentally disordered persons must be separated from the people they used to have dealings with. They must be taken to a place unfamiliar to them. Those who take care of them must also be strangers to them. In other words, they must be ISOLATED.''

The pedagogical environment that was believed to help restore the order of mind and behaviour was provided in the ideal asylum, located in beautiful scenery in the countryside and supervised by an ideal psychiatrist. K.A. von Solbrig [35], Professor of Psychiatry at Munich University and superintendent of the public mental hospital there, outlined the personality of the physician-in-chief as follows: ''The physician is the patients' God omnipresent . . . with the treasures of his material wisdom and experience . . . with the power of his phantasy, with the sharpness of his historical understanding of the world, with the visionary eye of a religious believer.''

Reflected in von Solbrig's thinking is an unbroken paternalistic understanding of how a psychiatrist should guide his patients back to morally proper behaviour:

> The asylum is . . . a school, a place to practise orderly life in a family and a community, well, in fact in a large community consisting of many families. In this community there is no loneliness of the patients. Strict rules exist, work alternates with leisure in a regular order under consideration of the ''moral, occupational, economic, artistic and general social instincts'' of each individual patient.'' [36]

The mental hospital of Illenau, Germany, hierarchically and strictly organized according to these principles and completed in 1840 according to C.F.W. Roller's plans—he was also its first superintendent—became a model for psychiatric institutions in the second half of the 19th century, widely copied in other countries as well.

In this early period of evolving health care systems, mental health services separated themselves from the general health care system and, hence, also from the progress in natural sciences and technology. The mental hospital moved out of the general hospital, consciously isolating itself. The above quotations also aptly illustrate the paternalistic way that mental patients were treated in those days and the rigid, hierarchical and authoritarian structure of mental hospitals, which, it was believed, helped patients to adjust themselves to an ideal civic order.

As its treatment strategies proved ineffective, the system was doomed to failure. The consequence was resignation and therapeutic inactivity. The patients were excluded from society and locked away in increasingly neglected mental hospitals. Only a few active superintendents—mainly in Scotland, England and the USA—together with the no-restraint movement promoted the idea of providing for mental patients the greatest possible degree of freedom, daytime activity, occupational therapy and discharge programmes. Despite these efforts, large mental hospitals continued to be run like prisons until after World War II. There mentally ill persons were detained frequently for several years often under inhumane conditions. Obviously, the system was incapable of reforming itself.

How psychiatrists regarded their patients is illustrated by the following quotation from Emil Kraepelin [37]: ''Let us now turn our minds to the severe forms of idiocy that make up the great mass of patients in our asylums: common to these people is the destruction of the unity of their psyche and personality, their exclusion from the human community and their social environment.'' This is an apt description of the stigma and discrimination associated with the isolation of mental patients in remote asylums.

The Perversion of Mental Health Care to Murdering Mental Patients in Germany in the National Socialist Era of 1939–1945

Against the backdrop of the blight of the mental health care system that offered no hope to its patients, and under the influence of social-Darwinist and eugenic ideologies, Hitler in 1935 signed an Act of Enablement that led to the compulsory sterilization of nearly 300 000 people truly or reportedly suffering from hereditary disease. It was his first radical breach of human rights. In 1939 the mass murder of some 200 000 mentally ill people followed. A considerable number of leading psychiatrists, young physicians, and administrative and nursing staff participated in the killing.

But the fatal neglect of the mentally ill was not limited to the National Socialist era. In both World Wars meagre resources were shifted away from the mentally ill, as shown by the death rates for mental hospitals in Germany during World War I [38] (Table 2.2). It is also shown by statistics from the asylum of Buckinghamshire, England, during World War I, where the death rate reached 43% in 1918 (Table 2.3). These figures make evident the low priority given to the mentally ill and the mental health care system as such in society in the past when life chances were being allocated. A fundamental change of attitude in society and on the part of governments was necessary to secure the right to life of the mentally ill.

TABLE 2.2 Deaths in mental hospitals in Germany during World War I, as a percentage of total number of inmates (number of inmates at the beginning of the year and new admissions). Reproduced from Faulstich [38] by permission of Landeswohlfahrtsverband Hessen

State/hospital	1914	1915	1916	1917	1918
Prussia	6.6	8.8	11.2	19.3	15.5
Eichberg	5.6	8.7	16.3	24.3	17.9
Weilmünster	7.2	10.0	17.0	36.5	30.0

TABLE 2.3 Deaths among about 600 inmates of the Buckinghamshire county asylum during World War I (data from Crammer [39])

Year	1910–14	1915	1916	1917	1918
Number	67	81	110	129	257
%	~ 11	13.5	18.3	21.5	43.0

The Rediscovery of Human and Civil Rights After World War II

Under the impression of the human and moral catastrophe that World War II left behind, the international community rediscovered humanitarian values and vowed to restore and strictly respect human and civil rights. The first evidence of this change of mind was the UN Declaration of Human Rights issued in 1948. In the wake of changed attitudes, it could no longer be ignored in what extremely inhumane conditions mentally ill people were forced to live in large mental hospitals. Sociologists, such as Irving Goffman in his widely heeded book *Asylums* [40], compassionately described the patients' living conditions and the bureaucratic organization of mental hospitals: the "total institution" ruled over every aspect of life, making the patients powerless, helpless and passive. Later, Wing and Brown [41], in their comparative study of three large British mental hospitals, demonstrated that social deprivation and cognitive understimulation led to secondary impairment in mental hospital patients, compounding primary, mental-illness-related impairment. The mass media grew increasingly sensitive to this problem. Unvarnished reports and pictures were published, especially from a few extremely neglected state mental hospitals in the USA. Mental hospitals were called "snake pits". A public scandal ensued.

The Transition of Psychiatry from Custodial Care to a Therapeutic Discipline

Well into the 20th century, psychiatry lacked not only effective therapies, but also a canon of wisdom of the morphological changes and patho-

physiological processes underlying most mental disorders. From the late 19th century on, clinical neuropathology made remarkable progress in understanding the morphological structure of the human brain and some of its functioning. In the wake of accumulating knowledge of brain dysfunctions causing motor and sensory disturbances, such as aphasia, neurology broke away from psychiatry and the mental health care system, first in high-income countries. What was left for psychiatry was disorders of unknown origin for which it had no cure yet. This is one of the reasons why psychiatry took considerably longer than other branches of medicine to establish itself as a scientific discipline in the 20th century.

A decisive factor contributing to the change of attitude in mental health care was the emergence of psychotropic drugs in growing numbers and a growing variety of efficacy from 1952 on. Essential in this process was also the advent of effective and economical psychotherapeutic methods, such as behavioural and cognitive therapies. Improvement in diagnostic techniques also played an increasingly important role. A revolution occurred with the advent of imaging techniques—such as computed tomography (CT), magnetic resonance imaging (MRI), single photon emission computed tomography (SPECT) and positron emission tomography (PET)—which allowed a non-invasive investigation of the morphology and functioning of the brain *in vivo*. Insight was gained into a remarkable number of morphological changes and functional processes. The growing sophistication of electroencephalogram (EEG) diagnosis by evoked potentials and topographic analysis, as well as magnetic encephalography, increased the understanding of functional processes such as attention, perception and cognition, as well as of the nature and localization of abnormal processes. New methods of investigation in the fields of biochemistry, neuroimmunology and molecular biology led—and are still leading—to great advances in diagnosing neurobiological anomalies and dysfunctions.

With these new technologies, most of which are also used in other medical disciplines, modern scientific medicine entered various domains of mental health care. Initially, this happened only in rich countries. But scientific methods and technologies will continue to pervade mental health care in medium-income countries as well, especially as cheap and practical instruments—such as microchips for DNA-pattern diagnosis—become widely available. Psychiatry grew into an integral part of modern medicine. It acquired objective means of diagnosing numerous neuropsychological and/or neurobiological dysfunctions that underlie abnormal behaviour and mental disorder. It acquired novel ways of intervening in psychological and neurobiological structures and processes and, as a result, a broader basis for evidence-based action in mental health care. Psychiatry was on its way to overcome the causes that had led to its exclusion from the system of physical health care and to its falling behind the scientific progress in medicine.

The Modern Mental Health Care System: Reintegration in the General Health Care System

Gradually, the traditional mental health care system started attracting greater public interest. Beginning in 1954, a series of reform efforts were launched. In his memorable 1963 speech US president John F. Kennedy called for ''a bold new approach in mental health services delivery''. Before that event, a Joint Commission on Mental Health (1961) had been appointed to analyse the mental health care system of the USA and to work out recommendations for its reform [42]. In 1953 a WHO Expert Commission issued recommendations that called for shifting the focus of mental health care delivery from the mental hospital into the community. The 1954 White Paper of the Department of Health and Social Security in England and Wales stated a policy of setting up psychiatric units at general hospitals and closing down public mental hospitals. These reform efforts paved the way for the return of mental health care to the general health care system in the countries mentioned.

The target of moving ''from hospital-centred custodial care to comprehensive community care'' was based on two leading ideas formulated in numerous WHO and national recommendations and policy plans. They also underlined the key role of social care as a component of the mental health care system:

1. The useless principle of isolating the ''insane'' from the community for therapeutic purposes was replaced by the paradigm of social integration. The mentally ill should no longer be separated from their natural environment, their family and their workplace. Mental health services and social support should be provided in the community to make it possible to rehabilitate and to resettle the disabled mentally ill.
2. The discrimination against and the disadvantages of the mentally ill on the legal level, in everyday life and in health care should be brought to an end. Physically and mentally ill persons should enjoy the same rights. Consequently, psychiatry should be integrated in general health care, from primary care to hospital care, on an equal basis. A mentally ill person coming for inpatient treatment should be able to enter the hospital through the same door as a renal patient coming for a dialysis.

A decisive step towards integration was the establishment of psychiatric units at general hospitals and the closure of large and remote mental hospitals. This policy, put into practice, meant that, at least with respect to hospital care, psychiatry was again part of the general health care system. Since then, psychiatric units at general hospitals have been subject to all changes, favourable and unfavourable, in the financing and organization of

general hospital care. Simultaneously, mental health care has faced the challenge of keeping up with the pace of progress in medical science and technology.

Even the seriously mentally ill and disabled mostly receive only short-term inpatient treatment in acute episodes and crises. To provide for their complex needs for long-term care, a network of services has been created that includes, as its basic components, medical, psychological, and social, as well as occupational and rehabilitative, care. Characteristic of this system is intersectorial cooperation in a comprehensive community mental health service. But, in trying to meet the multifarious needs of the seriously mentally ill and disabled, service structures may grow complex and difficult to coordinate.

In the British system of community psychiatric and social services, Leff *et al*. [43] and Knapp *et al*. [44] studied the effects of the closure of two mental hospitals in North London (Friern in 1993 and Claybury in 1996). Knapp *et al*. [44] demonstrated that even managing the accommodation of the chronic patients discharged into the community involved a variety of organizations. The authors identified six sectors and in each sector various agencies and institutions:

1. The National Health Service trust (formerly district health authority).
2. Local authority social service department.
3. Voluntary (non-profit) organization.
4. Private (for-profit) sector.
5. Local authority housing department.
6. Consortium (National Health Service with housing association and voluntary organization).

This example is not applicable to other countries, because traditions and national systems vary a great deal. But the problem is the same practically everywhere.

In highly organized, traditional health and social systems, the multitude of services and institutions now participating in mental health care and the variety of their sectoral backgrounds and accountabilities frequently lead to great difficulties in coordinating care delivery to meet patients' needs.

In countries where community mental health systems are set up from scratch as a policy decision, the preconditions are frequently more favourable for a centralized coordination of the services and integration of their components. Unlike psychiatric units at general hospitals, the complex community mental health care systems, due to their multisectoral nature and inclusion of other than health services, are special and difficult to integrate in traditionally organized general health care systems.

The new philosophy of comprehensive community mental health care instead of hospital care led to tremendous changes, particularly in high-income countries with large numbers of psychiatric beds. For example, in 1955, at the beginning of the process of dehospitalization, the USA had 4.5/1000 mental health beds and Great Britain 3.5/1000. Figure 2.1, however, shows enormous variation in the mental health bed rates of European countries in 1970 and, hence, great differences in the national backgrounds of mental health care reform. When all countries throughout the world with corresponding data are considered, the rates range from almost zero to nearly 7/1000 population. Almost all high-income countries, except Japan and Singapore, have enacted the closure of old, remote mental hospitals, and some have already put this policy into practice. In Great Britain, for example, of the 130 large mental hospitals still open in 1960, only 14 were left in 2000, and they were still being considered for closure in the years to come.

The humanitarian gain of the deinstitutionalization and community care programme has been demonstrated by several studies. Particularly the Team for the Assessment of Psychiatric Services (TAPS) study, evaluating the closing down of the two mental hospitals in North London, provided a thorough analysis of how patients fared after discharge, their housing conditions, and their acceptance by neighbours and the community, as well as of their symptomatology and behaviour [43, 46]. The study also assessed needs for care and costs [44]. Figure 2.2, taken from Knapp *et al.*'s study [47], illustrates an economic problem of modern community mental health care: the variance in the cost of accommodation for discharged patients across the sectors mentioned above.

THE SOCIAL COMPONENT OF MENTAL HEALTH CARE

The large-scale deinstitionalization programmes have shifted the burden of long-term care from hospitals to families and/or to social services. In low-income countries and in many traditional cultures, the families are alone responsible for giving informal care to their mentally disabled members under the paradigm of kinship solidarity or according to religious codes. The enormous variation in the role of family care in different cultures is shown by the proportions of patients with chronic schizophrenia living with their family: about 70% in Bologna, Italy, but only 13% in Boulder, Colorado [48].

But due to demographic, social and cultural changes, the numbers of potential care-givers are declining in most countries. When family members are no longer available, expensive social and complementary services must take their place. Serious deficits in this respect are bound to lead to the destitution of the mentally ill as in medieval times, as shown, for example, by Fuller Torrey in 1980 for the USA [49].

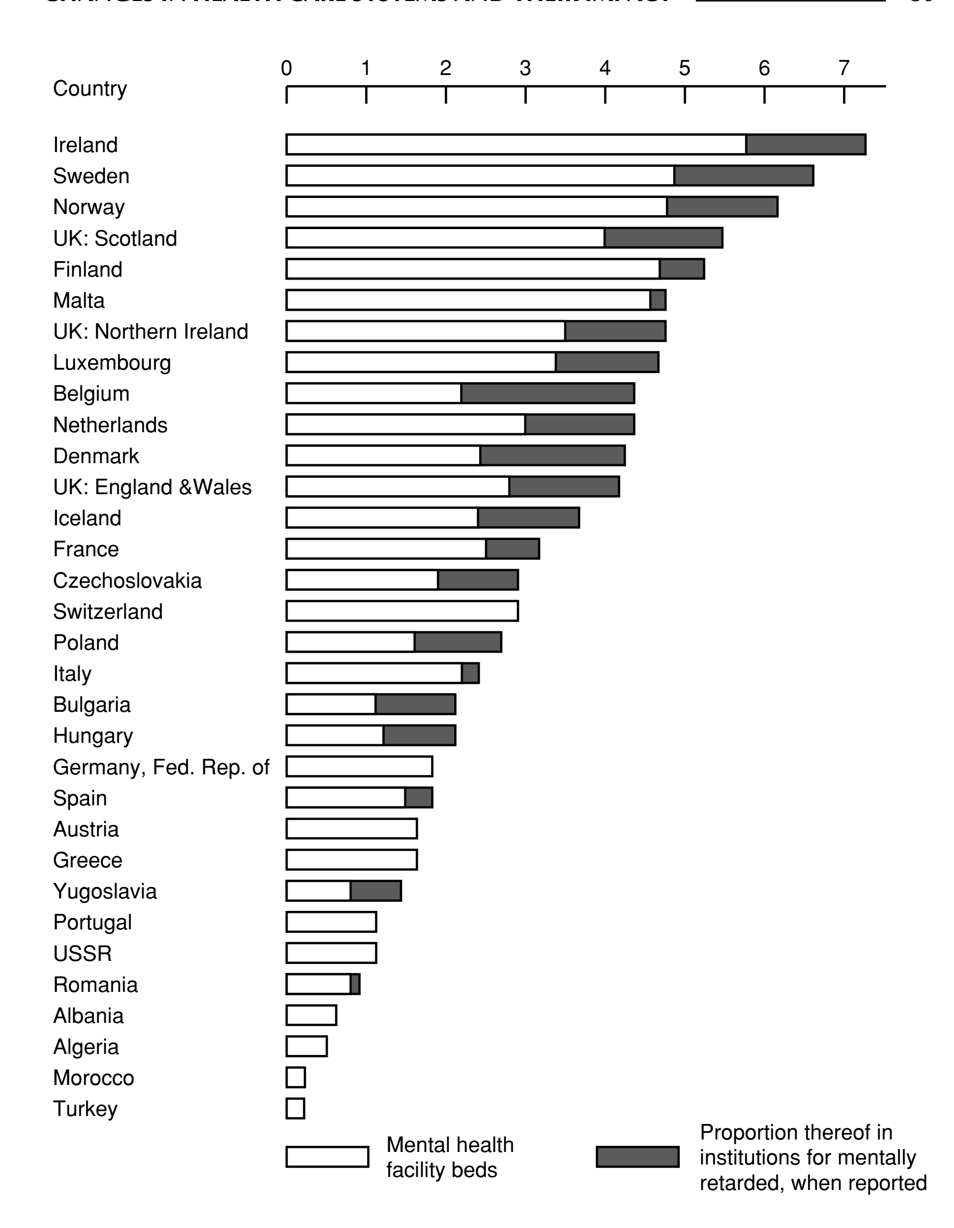


Figure 2.1 Reported number of mental health facility beds per 1000 population in 1970. Reproduced by permission of the World Health Organization [45]

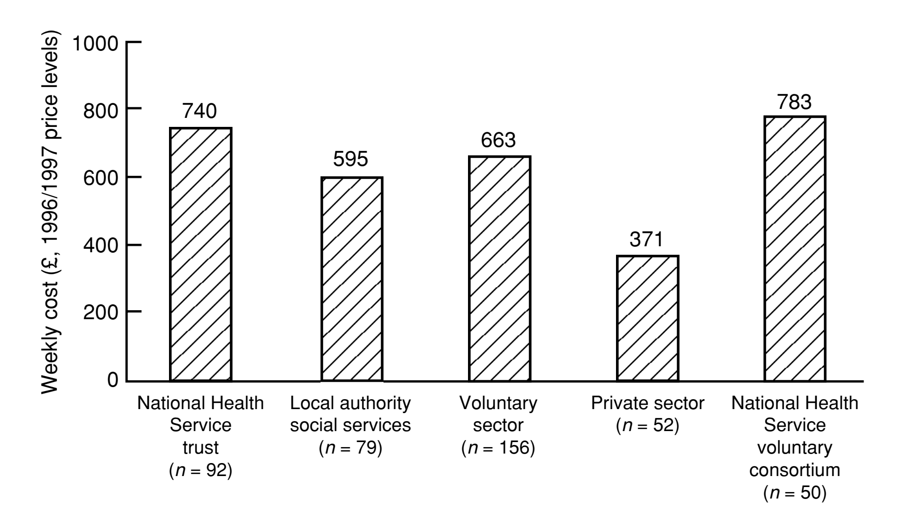


FIGURE 2.2 Community care accommodation: costs by sector in UK. Reproduced from Knapp *et al*. by permission of Demeter Verlag [47]

SOCIAL AND CULTURAL CHANGE AND THE INFLATIONARY GROWTH OF NEED FOR TREATMENT

Religious societies, past and present, regarding this life merely as a transition to the life to come, interpret mild mental disturbances, such as grief and depression, as belonging to the *conditio humana*. The afflictions in life, given by God, should be suffered in patience. Relief is to be expected only in the beyond.

In secularized societies with increasing civilization and education, with the growing successes in somatic medicine and finally also in psychiatry, more and more people seek help from the health care system not only for physical, but also for mental problems. The consequence has been an enormous increase in demand for psychiatric treatment.

Treatment tools have expanded with the emergence of short and teachable forms of psychotherapy. The discovery of psychotropic substances finally made it possible, in countries where these drugs were available to everybody, to treat large numbers of mental patients at low cost and low risk.

In secularized cultures and countries, the availability of potent therapies led to an enormous increase in the utilization of mental health services. This was reflected in great differences in the prevalence rates for all mental disorders—defined by need for care to some extent—reported from

population studies that have compared different time periods as well as religious and secularized cultures. Table 2.4 illustrates this with data from selected prevalence studies. In recent population surveys, conducted with standardized instruments, these cultural differences are still visible in clearly higher prevalence rates for the secularized societies of market economy countries.

A good example of the expansion of disease definitions in the wake of increased demand are eating disorders. By about the mid-20th century they were diagnosed and treated only after they had led to serious physical health risks (e.g., anorexia nervosa).

Whether, with increasing supply, the demand for psychiatric services will continue to grow in the future and whether there are any limits to this growth, is still difficult to see. At any rate the steep increase in mental health services in market economies has been associated with a clear increase in costs. At the same time the costs of general health care, too, have increased.

In countries now at the beginning of this process it is to be expected that a growing secularization of religious cultures and improvements in educational systems will increase demand for mental health services. These countries should therefore take the precaution not only of improving physical health care, but also of providing more and better mental health care in the process of economic growth and social development.

The human and moral catastrophe of World War II led to a deep respect for human and civil rights worldwide. In the post-war era, individuals, nations and international organizations tended towards an outlook on life corresponding to that longing. It was characterized by a keen interest in social justice and in protecting minorities and the needy. The mental health care system profited from this trend, which in some Western countries culminated in the student protests of 1968. The new climate laid the basis for reform efforts in mental health care and for mobilizing people for voluntary services and organizations promoting the cause of the mentally ill.

Table 2.4 Cross-national comparison of the prevalence of all DSM-III-R disorders (persons with one or more diagnoses, both sexes together) (data from WHO [8])

	Brazil	Canada	Germany	Mexico	Netherlands	Turkey	USA
Lifetime prevalence	36.3	37.5	38.4	20.2	40.9	12.2	48.6
One-year prevalence	22.4	19.9	24.4	12.6	23.0	8.4	29.1
Male–female ratio	1.2	1.2	1.3	0.7	1.7	3.3	1.5

With the dehospitalization of mental patients and the transition to multidisciplinary community mental health teams, the interest of social services in mental health care grew considerably. The result was, besides necessary cooperation, also competition. In some countries, such as Denmark, psychiatric hospitals and community mental health services were integrated in the system of social services. As a consequence of this policy decision, again, a large proportion of mental health care was separated from the general health care system, removed from its shortly regained proximity to progress in modern medicine, and exposed to the risk of sinking medical standards. For lack of suitable studies, it is not yet clear whether this development has led to a better social care.

In the last two decades, due to revolutionary discoveries in molecular biology, genetics and other biological disciplines, a change to a more biologically oriented view of life has occurred in the public. As a consequence, psychiatry, too, has become more biologically oriented.

Contributing to these developments have been the above-mentioned advances in pharmacotherapy, imaging techniques and molecular biology as well as—given the influence of the media on public attitudes—the health risks posed by the pandemic of such diseases as Alzheimer's disease, AIDS and bovine spongiform encephalopathy. Correspondingly, the young generation of medical students and physicians are primarily attracted to biological disciplines. As a result, the pool of young people willing to work in mental health care, in community care in particular, is bound to shrink considerably in several countries. This once again underlines the fact that, in its combination of biological and psychological knowledge and techniques and a social dimension of therapeutic action, mental health care can never fully be merged in general health care. But it is equally plain that mental health care must remain rooted in medical science.

THE FINANCIAL CRISIS OF THE HEALTH CARE SYSTEM: SHIFTING THE COSTS OF HEALTH CARE BACK ONTO USERS

Since World War II, health expenditures have risen continuously in Organization for Economic Cooperation and Development (OECD) countries. For member states classified as established democracies, health expenditure as a percentage of the GDP was 2.3% in 1960 and as high as 6.1% in 1996. Total health expenditure, i.e., public and private expenditure taken together, rose from 3.8% to 8.2% (Table 2.5). The factors contributing to this increase are complex. In rich countries there has been an enormous increase in elderly populations with high rates of health care utilization. Another factor is the

Table 2.5 Public and private health expenditure as a percentage of the GDP in OECD member states, 1960 and 1996. Reproduced from Schmidt [52] by permission of Springer–Verlag

	Health expenditure as a percentage of the GDP 1996[1]			Health expenditure as a percentage of the GDP 1960[2]		
	Public and private	Public	Private	Public and private	Public	Private
Established democracies						
Australia	8.4	5.6	2.8	4.9	2.4	2.5
Austria	7.9	5.9	2.0	4.4	3.1	1.3
Belgium	7.9	6.9	1.0	3.4	2.1	1.3
Canada	9.2	6.6	2.6	5.5	2.3	3.2
Denmark	6.4	5.1	1.3	3.6	3.2	0.4
Finland	7.5	5.6	1.9	3.9	2.1	1.8
France	9.6	7.8	1.8	4.2	2.4	1.8
Germany	10.5	8.2	2.3	4.3	2.8	1.5
Great Britain	6.9	5.8	1.1	3.9	3.3	0.6
Greece	5.9	4.9	1.0	2.4	1.5	0.9
Ireland	6.0	4.9	1.1	3.8	2.9	0.9
Italy	7.6	5.3	2.3	3.6	3.0	0.6
Japan	7.2	5.7	1.5	3.0	1.8	1.2
Netherlands	8.6	6.6	2.0	3.8	1.3	2.5
New Zealand	7.2	5.5	1.7	4.3	3.5	0.8
Norway	7.9	6.5	1.4	3.0	2.3	0.7
Portugal	8.2	4.9	3.3	2.8	0.8	2.0
Spain	7.6	6.0	1.6	1.5	0.9	0.6
Sweden	7.2	5.9	1.3	4.7	3.4	1.3
Switzerland	9.8	7.1	1.7	3.3	2.0	1.3
United States	14.2	6.7	7.5	5.2	1.3	3.9
Mean	8.2	6.1	2.1	3.8	2.3	1.5
Other OECD member states						
Czech Republic	7.9					
Hungary	6.7					
Mexico	4.5	2.7	1.8			
Poland	4.4	4.1	0.3			
South Korea	5.3	2.1	3.2			
Turkey	5.2	2.6	2.6		0.7	
Mean	5.67					

[1]Data for 1995 concerning Japan, Sweden, Switzerland, Spain and Czech Republic.
[2]Data for 1970 concerning Portugal.
GDP: gross domestic product; OECD: Organization for Economic Cooperation and Development.

expansion of health services, caused by a considerable increase in demand and the progress made in medicine in the wake of the emergence of new, costly diagnostic and therapeutic technologies.

After the integration of the mental health therapy sector in the general health care system, mental health services have been affected by the financial and organizational reforms undertaken by governments to contain health expenditures in general. These measures, however, do not affect all domains of health and mental health care in the same way.

The last decades of the 20th century were therefore characterized by numerous efforts to reform systems of health insurance and health care. A global indication of where these systems are headed is not yet discernible. In most countries an attempt is being made to replace particularly expensive forms of treatment by cheaper ones wherever possible without loss to the quality of care. In mental health care, the programme of dehospitalization and transition to extramural care was also widely seen as the method of choice for containing costs. As a result, the number of available mental-health beds in many high-income countries had been cut by half or even more by the end of the 20th century.

In most countries with former communist governments and state-run mental health care systems, the new governments, after the collapse of communism, assumed the responsibility for providing health services. In some of these countries, due to shortages of various kinds and political and administrative disarray, the health care systems have nearly broken down. Lack of continuity in the provision of services and the current shortage of medications, as well as of almost all imported goods, hit the mental health care sector particularly hard.

To contain health costs, the state-controlled and solidarity-based systems have had recourse to rationalizing and rationing health services provision. The measures adopted differ from country to country. Those preferring more gentle solutions apply quality control and evidence-based medicine in trying to exclude from financial coverage ineffective services, such as inefficacious treatments and medications.

An example of rationing by degrees is the reform of the Swedish health care system launched in 1995. Under the guiding principles of human rights, solidarity and cost-effectiveness, five levels of priority were defined: 1) life-threatening or acute illness with a risk of outcome in lethality, disability or chronicity; 2) efficient preventive and rehabilitative interventions; 3) minor acute and chronic illness; 4) borderline cases; and 5) health problems not classified as illness. Mental health services are subject to rationing according to these principles to the same extent as health care in general. It is not yet clear how successful this hierarchical approach based on crude criteria has been.

Ireland has reformed its health care system using people's ability to pay as a criterion for eligibility for benefits: for the least well-off third of the

population, health care services, paid from tax funds, are free. For two-thirds of the population, severe health risks are partly covered, and the rest is paid by private insurance schemes.

Internationally most influential has been the attempt to curtail public health expenditure by introducing free market mechanisms in the financing and provision of health services. The aim is to cut costs by bringing in market forces and competition, a policy which seems to have succeeded in the USA, and by encouraging quality control on the provider side. But success is not guaranteed by merely introducing this system.

Countries have chosen different paths in bringing in market elements in their national health care systems. In 1989, the Thatcher government in Great Britain, for example, tried to establish an internal market between service providers, such as hospitals and general practitioners (GPs), and the buyers of these services, such as local authorities. The system was no longer financed from government budgets, but on the basis of contracts. In this way the GPs participating in the system were no longer employed by the state, but became, to a limited extent, profit-oriented entrepreneurs.

Because of widespread dissatisfaction with that system, the Blair governments of 1997 and 2001 have again increased state involvement and control. The entrepreneurial responsibility of GPs, the so-called fundholding, however, has been retained and extended to all GPs. In this case, too, it is still unclear whether scaling down state involvement in the allocation of resources will help to increase efficiency, shorten waiting lists, increase fairness and reduce costs. What is clear though is that mental health care will be affected by the same problems and consequences of the reform as the general health care system.

The social domain of mental health care is influenced particularly by the existing system of social services, their financing and cooperation or overlap with the mental health care system. As already mentioned, the systems vary a great deal.

The prevailing, most frequently copied market economy system in health care, mainly practised in the USA, ''managed care'', is rather complex. The predominant type of managed care company, HMO, runs care delivery systems that provide health services to customers in exchange for a prepaid fixed fee. Benefit packages usually cover a full range of services, including visits to physicians, inpatient care and laboratory tests. Hence, the HMO companies act both as health insurers and as entrepreneurs that provide health services.

HMO companies offer health benefit contracts to individual clients, companies and state governments. On the provider side, there is generally a variety of health services, such as hospitals, GPs, laboratories, etc., that contract with or are run by the HMO companies. It is undoubted

that managed care has advantages on the supply side as a tool for effective utilization management that ensures the coordination of medical, rehabilitative and social interventions according to individual treatment plans.

The growth of the managed care system has been fast, and considerable concentration of business has occurred. Two companies already share over 50% of the US market. Growth and concentration result from the fact that the ''production'' of health services has become an object of entrepreneurial activity. The companies active in this field, but also the doctors, hospitals and laboratories that have contracted with the managed care companies or entered partnerships as providers of health services against prepaid fees, can expect to earn profit.

A key instrument of the HMO companies for earning profit is withholding services that are deemed unnecessary or substituting less expensive for more costly care [53]. One way of achieving this end is to exclude from coverage inefficacious medications; another is to introduce copayments for drugs, remedies and aids—in the USA and Canada they have reached a maximum now. A special problem is risk selection. Profit-oriented companies are naturally tempted to exclude or limit the coverage of cost-intensive health risks. In doing so, they jeorpardize fairness. This is the case when health benefits for patient groups with particular sets of disorders, such as mental disorders or substance abuse, or for specified types of treatment are carved out. An alternative would be to offer more expensive contracts for those wishing coverage for such cost-intensive health risks. For example, Buck and Umland [54], examining a convenience sample of 171 employers, found that one-fifth of the employers carved out mental health and substance abuse from at least one of the medical plans offered.

To prevent adverse selection and the mentally ill from being disadvantaged in the managed care system, a multiple-plan approach with risk-related payments would be needed. However, such models are rarely accepted by customers with the lowest health risks. The chances of achieving full consumer cost-sharing in consumer-friendly health plans are limited, because the consequence would be higher premiums. ''The result is that plans with more generous coverage [for mental disorders and substance abuse] are simply unavailable'' [55].

This illustrates how difficult it is in market-oriented health care systems to prevent discrimination against persons with chronic mental disorders or substance abuse in need of cost-intensive, long-term care. Consequently, it is hardly possible to preserve fairness without government involvement. An example of a positive solution is the Massachusetts Group Insurance Commission (GIC) health plan for governmental employees, which avoids mental health carve-outs by uniform coverage and utilization management for mental health services. However, this health plan, too, like those pro-

vided by other US states for their governmental employees, preserves fairness only for a small population group.

Assessing the risks for mental health care of policies introducing the marketplace in health care systems, David Mechanic [53] concludes: ''On a profit oriented, unregulated health care market the seriously mentally ill and disabled with long-lasting and multifarious needs for medical, psychological and social care are clearly disadvantaged. For this reason the US Center for Mental Health Services is pushing for a governmental safety net.''

In the countries that have adopted managed care systems—among them are not only high-income, but also many medium-income countries—mental health care systems are more or less in danger of losing fairness when the seriously mentally ill and people with substance abuse disorder are disadvantaged to a greater extent than the physically ill or people with minor mental disorders. For this reason, the WHO is justly calling on governments as stewards of health care systems to make every effort to secure fairness in health care [1].

Another, mostly unsolved problem of national health care systems is a parallel supply of health services by traditional and new, market-oriented systems. In the USA, mental health benefits are provided by: (a) the managed care system offering health plans for the employees of large companies and state governments; (b) the federally funded system of cost-free mental health care for the poor; and (c) the Veterans Administration's comprehensive system of health and mental health services for former service personnel [56].

The problem of an uneconomical parallel supply of health services also exists in some socialist countries, where besides a state-run or a Bismarckean type of solidarity-based health care system, market economy mechanisms, managed care systems in particular, have been introduced [57].

MENTAL HEALTH CARE IN LOW-INCOME COUNTRIES

The previous discussion focused on high- and medium-income countries, where financial and human resources are sufficient for maintaining health care systems that more or less meet people's needs. ''Human resources are vital'' for a health care system, states the *World Health Report 2000* [1], underlining that despite sufficient financial resources an adequate mental health care system can only be maintained if ''different kinds of clinical and non-clinical staff who make each individual and public health intervention happen'' are available [1].

Most low-income countries, however, through shortage of money and lack of institutions for educating and training health care personnel, do not have enough human capital for the health care field. Table 2.6 gives an

TABLE 2.6 Mental health care resources in some selected countries. Data from WHO [58] reproduced by permission of the World Health Organization

Country	Psychiatric beds per 10 000 population	Psychiatrists per 100 000 population	Psychologists per 100 000 population	Nursing personnel per 100 000 population
Albania	2.5	0.9	N.A.	3.0
Australia	7.4	9.2	N.A.	N.A.
Belgium	19.0	10.0	6.6	67
Brazil	6.7	3.2	63	N.A.
China	1.1	1.1	N.A.	N.A.
Denmark	7.0	8.4	1.1	135
Great Britain	15.0	2.4	1.5	111
Italy	8.0	4.4	0.4	N.A.
Japan	35.7	7.1	N.A.	N.A.
Korea	2.9	1.6	N.A.	N.A.
Malaysia	2.3	0.3	N.A.	N.A.
Myanmar	0.4	0.1	<0.01	0.3
Netherlands	16.0	2.3	2.1	72
Norway	8.0	7.8	7.2	210
Philippines	1.1	0.03	N.A.	N.A.
Spain	7.0	3.9	0.8	22
Sri Lanka	0.2	0.2	N.A.	N.A.
Sweden	17.0	9.7	6.8	362
United States	11.2	13.1	22.8	4.3

N.A.: Information not available.

impressive overview of the mental health care resources of 19 selected countries. It illustrates not only the enormous variance, but also demonstrates that in some countries there is a glaring shortage of psychiatrists; for example, the Philippines has only three psychiatrists for 10 000 000 population, Malaysia and Sri Lanka three and two for 1 000 000, respectively. In these countries, specialized psychiatric care is practically impossible.

I asked a few leading psychiatrists in selected countries for information on some indicators of their national mental health care systems. Table 2.7 shows that many countries lack adequate mental health care. Is there anything that can be done to maximize all the available resources, to provide care at least in severe mental health problems and to allocate some of the scarce resources also to poor countries and to the economically underprivileged sections of the population?

The WHO recommends that governments work out national mental health policies: ''A mental health policy highlights the importance of mental life'' in a nation [58]. The Declaration of Montreal [59] states the components of mental health policy. The focus lies on the local community, because social support and social integration for the mentally ill require rapid access

Table 2.7 Mental health care indicators in selected countries

Country (informant)	Coverage of costs of mental health services	Psychiatric beds per 10 000 population	Number of psychiatrists/ population	Care-giving for disabled
China (Shen Yucun)	Mainly private; small coverage by state	0.8	About 1 per 100 000	Families, public health insurance in planning
Denmark (P. Munk-Jørgensen)	National health service (public)	7.6	About 1 per 5500	Families (under heavy burden), social services
Egypt (A. Okasha)	Public hospitals free Health insurance: <16, >65, plus private	1.2		Families alone
Finland (V. Lehtinen)	National health service; small private contribution	25.0	About 1 per 6500	Families, social services
Great Britain (G. Thornicroft)	National health service; small private contribution	4.5	About 1 per 10 000	Community and social services, families
Hungary (I. Bitter)	National health service (small coverage plus private contribution)	9.7	About 1 per 13 500	Families, social services
India (R. Srinivasa Murthy)	Public health insurance (less than 10% access to services)	0.3		Families alone
Italy (G. de Girolamo)	National health service (small coverage plus private contribution)	1.3	About 1 per 7700	Families, social services
Japan (N. Shinfuku)	Public health insurance (not all services included)	29.0	About 1 per 10 000	Long-term residential care, families
Russia (V. Krasnov)	Public health care (alcohol and substance abuse not covered)	1.2	1 per 9268	Families, social services

to diversified resources that are integrated with the community and centred on the potential of the individuals in their own living environment.

As stated at the outset, mental health policies should not be limited to caring for the ill, but should also include the development of preventive and promotive programmes, for which families of the mentally ill, former patients and their social environments should also be mobilized. The aim should be to reduce substantial mental health problems, arising from factors such as poor living conditions, social isolation, unemployment and demoralization, exposure to violence, etc. Programmes of this type could be realized by tapping existing resources, as they require only little outside financial support, particularly from the government. Again, the social component of the mental health care system is evident, and usually there are cheap resources available to practise it.

According to the WHO Declaration of Alma-Ata [60], the need for treatment in mental or substance abuse disorders is best met by integrating the scarce psychiatric resources in the primary health care system. This can be done by training general practitioners, nurses and other health care staff especially in the diagnosis of serious mental disorders and the administration of suitable psychotropic drugs [60]. In this way mental health care is made an integral part of primary health care. Including in the mental health care system native healers with their traditional treatments is currently being viewed with greater reservation [9].

The poorer a country, the lower the income of its population, the more important it is to work out a practical, clearly formulated mental health care policy plan, and to gauge existing resources and integrate them in the health care system. The emergence of a parallel system of private, market-oriented services is associated with a great risk, especially in low-income countries, of serving only a tiny, economically privileged fraction of the population and, hence, of violating the principle of fairness [9].

THE RISK OF ALIENATION OF COMMUNITY MENTAL HEALTH SERVICES FROM THE GENERAL HEALTH CARE SYSTEM

With the shift of mental health care into the community, a large proportion of psychiatrists, psychologists and nurses have moved out of the hospital into multiprofessional community teams. In this process they have lost their ties to their colleagues at the hospital and, thus, an opportunity for exchanging opinions, providing support to each other and a protective work environment [61]. They have also become separated from their colleagues in physical health care.

The system of community mental health care has undeniably brought the mentally ill more comprehensive and closer to life care, greater freedom and improved quality of life [46]. In patients with schizophrenia, even chronic negative symptoms have improved. A further consequence has been that psychiatrists are now working in multidisciplinary community mental health teams with non-medical professionals, such as social workers, occupational therapists and community nurses. A considerable part of their time is spent discussing and providing social care and interventions. The proportion of psychiatrists' work concerned with diagnosis and therapy has considerably shrunk compared with the work in psychiatric teaching hospitals and units for acute care. Psychiatrists in community mental health teams are cut off from scientific progress in diagnosis and therapy almost in the same way as their colleagues in the large mental hospitals were more than 50 years ago. An important point in this context is that it has become difficult in these new work environments to provide comprehensive state-of-the-art training for psychiatrists, as reported from Italy [62, 63].

It is not yet clear whether the closure of all mental hospitals for the care of the chronically ill will have only favourable effects. Recently, Munk-Jørgensen [64] showed, based on the National Danish Case Register data, that parallel to the decrease in psychiatric beds in Denmark from 1.6/1000 in 1980 to 0.76/1000 in 1998 the rates for crime and suicide among the non-hospitalized mentally ill compared with the general population increased steadily and considerably in Denmark. Several recent large-scale epidemiological studies of the risk of violence among the mentally ill have consistently demonstrated that an increased percentage of alcohol and substance abuse and deficits in psychopharmacological treatment and individual care increase the risk of violence among the discharged mentally ill patients [65–68]. Munk-Jørgensen [64] concludes that the closing down of mental hospitals has brought significant improvement for the majority of patients at the expense of deteriorated conditions for a small fraction of extremely vulnerable patients. Therefore, a more differentiated approach is needed in the planning and organization and the availability of residential, particularly hospital, care for highly vulnerable groups among the seriously mentally ill. A closer connection with the general health care system would probably also be necessary.

Another problem is the serious burden that caring for the mentally ill in the community places on the mental health care staff. Studies on the topic have shown that the burden is markedly greater among community than among hospital staff [69]. A large number of psychiatrists in community mental health care teams retired prematurely or left the programme after a short while, and a great proportion of the remaining staff were suffering from mental health problems and somatic ailments or even the burnout syndrome. This is another reason why it has become increasingly difficult to

find young people willing to work in this mental health care field. Here, too, the separation of psychiatrists and other mental health staff from the protective work environment of a general health care institution seems to be an important factor. The professional environment in a general hospital with interdisciplinary cooperation provides support in work, opportunity for permanent education and help in solving difficult tasks. The predominance of social care tasks associated with the risk of alienating the psychiatrist from the general health care field could lead to an increasing loss of expertise. To prevent this from happening, comprehensive and carefully planned training is needed.

At the same time, two closely connected areas of mental health care are threatening to break apart. Inpatient acute care provided at psychiatric units in general hospitals and, hence, integrated in the general health care system, will benefit from accumulating professional knowledge, new and better technologies and therapeutic approaches, and will undergo increasing specialization and impressive improvement in the quality of care provided. The outpatient psychiatric care for those patients not in need of psychosocial treatment or support will probably also undergo growing specialization with future advances in modern inpatient care. The psychosocial care of the seriously and chronically mentally ill, however, which should be functionally closely connected with acute care, will be in danger of losing its standards and of being separated from the general health care system.

In this respect, it is not yet clear in most countries where the mental health care systems are headed nor can the future perspectives be fully fathomed yet. One thing, however, is sure: the breakaway of no matter which part of mental health care from the general health care system is bound to harbour great risks for both the health care personnel and the mentally ill.

CONCLUSIONS

In most countries around the world, the strictly medical and in part also the preventive sector of the mental health care system became integral parts of the general health care systems at a comparatively late date. But discrimination against and stigmatization of the mentally ill, their families and, to some extent, the treatment facilities, too, still occur. The mental health care system is affected by all the favourable and unfavourable developments in the general health care system. The mental health care system is profiting from the multidisciplinary setting and the scientific progress in diagnosis and therapy in the field of medicine. But it is also suffering all the consequences of cost containment and health policy changes. Particularly the quality and fairness of the care of the seriously mentally ill, given their

complex and long-term needs, are threatened by economic constraints and structural changes.

The mental health care system itself is currently undergoing rapid changes. Its medical component, psychiatric inpatient and outpatient care, is profiting from integration in general medicine. Its psychosocial and community psychiatric component, responsible for the care of the seriously mentally ill, is mostly located outside the centres of general health care and hence is to a considerably lesser degree integrated in the general health care system. As a result, it is to a far greater extent exposed to the political, practical and individual uncertainties emanating from a nearly total lack of an institutional framework. In addition, the community psychiatric component is at risk of not being able to profit from state-of-the-art training, and from progress in psychiatry, as well as from the support and cooperation provided by a professional work environment. These problems are still greater in low-income countries with scarce human resources. For this reason it is very important to provide comprehensive training and ensure intensive cooperation with the general health care system, especially the primary health care sector, for psychiatrists working in outpatient services in the community. In the long run some form of institutional framework will be needed for the psychiatric staff primarily engaged in social care, in order to maintain the political and economic stability of care provision and to attract young people to working in this field. ''We must include solutions and care for mental health in our search for a better life for all in a systematic way. Only then will our success be more meaningful'', said Gro Harlem Brundtland [70] in her address on the occasion of World Health Day 2001.

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CHAPTER

3

Globalization and Mental Health

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INTRODUCTION

Great technological and social changes have taken place over the last decade, making it easier for people from far distant countries to be in much closer contact. Today, people living in New York can live in a ''virtual Calcutta'' connected through the Internet. Together with these changes in technology, the global political environment has radically changed. The abrupt decline of socialist economies has resulted in the unrivalled predominance of free-market economic approaches that encourage the movement of capital across frontiers and competition in a world with fewer trade barriers. Global capitalism has been victorious and many of the smaller countries of the world have economies dwarfed by some of the massive multinational corporations. Governments that attempt to exert their own influence on these corporations risk a flight of capital and a consequent loss of jobs and national income. These changes have played a major role in the resurgence of what has been called ''globalization'', a phenomenon that is not new, but that appears to differ from other historical epochs in sheer speed of change and its reach to almost all areas of the world.

Globalization, it can be argued, is causing major changes to all aspects of our life and in all areas of the world. It is likely to be the single most important influence on our lives in the years to come. In this chapter we shall discuss what is meant by globalization, and how it might influence some of the key social variables that have been studied in relation to mental health. In particular, we will discuss the influence of globalization on socio-economic inequalities between and within countries and on gender. There has been little study of the effects of globalization on health, whether physical or mental. However, we shall review some of the literature that describes the study of socio-economic status, gender and mental health. We

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shall concentrate on depression and anxiety, the common mental disorders [1] that have the most impact on the world's health.

What is Globalization?

The popularity of the term ''globalization'' does not match up with an agreement on its definition. Depending on where the term ''globalization'' is used—economy, communications, or cultural domains—it seems to have a different meaning. Most of these definitions involve a common element of a worldwide scope. Nevertheless, of all these definitions it is probably the economic ''globalization'' of the world shaped by the most powerful economic groups that most often attracts the use of the term. Globalization is associated with a capitalist agenda that argues for the removal of trade barriers, in order to improve efficiency and increase world trade. Companies are increasingly competing in a worldwide marketplace, and manufacturing is increasingly concentrated in places that can produce the goods most efficiently, wherever in the world that place might be. Nation states, according to this model, are therefore competing with each other by attracting foreign capital investment. The reduction of welfare costs for employers, ''flexible'' working patterns and making it easy for employers to hire and fire are all matters that will affect investment decisions. An educated and well-trained workforce is a further attraction.

In defiance of its own definition, ''globalization'' has only been partial; many countries have been excluded, and many others are only passive, powerless participants, unable to negotiate on equal terms with the big global economic forces, whether national or corporate. Many countries in the ''global club'' have experienced huge social transformations as a result of this phenomenon, although for some of the poorest nations transformation has been delayed by global forces. Last but not least, the collective, integrative element of globalization has been applied much more extensively in the financial world than in other social domains. In fact, there is some concern that the competitiveness introduced by globalization has led to much more individualistic societies. For many commentators, globalization is not a positive phenomenon, but a reflection of the excesses and inefficiencies of the free market model.

Globalization and Socio-economic Conditions

''Globalization'' is advocated by some international financial organizations as a powerful tool to combat poverty. The World Bank, International Monetary Fund and World Trade Organization [2] all pursue policies that

encourage the free movement of capital and trade and encourage economies to open their borders to the cold winds of international competition. These policies, it is argued, increase the rate of economic growth in the world economy and therefore lead to benefits for everyone. Alternative economic theories, however, point out that in a free market the strong usually gain victory over the weak. As a result, the recent World Trade Organization meeting in Seattle was disrupted by those who see globalization as a policy that advantages the strong, developed nations at the expense of the poor countries in the world. The opponents of the ''globalization'' agenda also fear the increasing power of multinational corporations over their own governments and common goods such as the environment.

The World Bank has been an active promoter of economic ''globalization'', but their own figures illustrate that poverty in the world has decreased only marginally and inequalities within and between countries have remained as large as they were before ''globalization'' or might even have increased somewhat [2]. According to the World Health Organization (WHO), approximately half of the world's population do not have anything close to a decent standard of living, about 3 billion people live on less than US$2 a day, and the average African household consumes 20% less today than it did 25 years ago. There are areas of the world, particularly South East Asia, that have seen rapid rates of economic growth and appear to have benefited economically from growth in the world economy. But there are many more areas of the world, especially in sub-Saharan Africa, that are still trapped in extreme poverty. Overall, there seems to be no reason to celebrate; the benefits of economic globalization are spread thinly and in patches. Globalization may have benefited some areas of the world, but there is an increasing view that it has also failed to bring prosperity to some very poor nations and communities.

Globalization has led to the increasing power of multinationals in relation to national governments. Governments have to try to attract investment from large companies in order to provide employment for their populace. One of the features claimed to make countries more attractive is to provide a ''flexible'' workforce. A ''flexible'' workforce can mean different things for different employers. It is often interpreted as leading to less security of employment, fewer social benefits and an erosion of workers' rights. Some of these changes might be perceptual, but the changes have often been accompanied by more job insecurity and apprehension for the future.

Demand and competition for scarce skills have contributed to increasing inequalities in income in some countries. The rich countries have also attracted people with scarce skills from poorer countries to more attractive posts in the West. There has always been a ''brain drain'' from less wealthy to more wealthy regions and countries. Globalization, it could be argued, is just accelerating this process. Globalization might therefore be influencing

both the inequalities within countries as well as the relation between countries. Globalization has also had an effect on the different roles of men and women. In some countries the position of women in the workforce has changed dramatically. In many of the more developed countries the proportion of women in paid employment has increased. Despite this, women remain in less well-paid employment and in jobs with lower status. In some societies, poverty can often place a considerable burden on women, because of their role in caring for their families.

Globalization has also had an impact on where people wish to live. Developed countries have had an increased flux of immigrants trying to cross their borders. Within countries, people can move more easily and have better information on where to go. In many countries there are huge numbers of people, the seasonal workers, that are in permanent motion, abandoning families and disrupting their natural social support networks. ''Globalization'' has had an important impact on the strength of the social matrix of society. According to the *World Development Report 2000/2001* [2], the poor seek more than a higher income; safety, predictability, and freedom to choose are also wanted.

Globalization has therefore led to a number of changes and is likely to lead to more changes in some of the key variables that have been of interest to public health and that are likely to affect rates of mental disorders. Globalization of the world economy is likely to affect socio-economic inequalities and differences in the social roles occupied by men and women.

Mental Disorders and Public Health

For the clinical psychiatrist, the most disabling and important conditions are schizophrenia, other functional psychoses and dementia. However, from the perspective of public health, depression and anxiety are very common and, though less disabling for the patients, lead in aggregate to more disability in the population as a whole. Of course, there is much evidence for a strong association between depression and disability in both developed and less developed countries [3–5]. Common mental disorders have also been linked to diminished productivity and sickness absence. These statistics reflect observations all too familiar to practising clinicians in primary care and psychiatry.

Despite the empirical and clinical evidence for a substantial population disability associated with depression, it has proved difficult to establish depression as a public health priority. Public health priorities have relied mainly upon comparisons of mortality statistics and have neglected conditions that lead to morbidity. The World Bank attempted to address this deficit by adopting a methodology that calculated the Disability Adjusted

Life Years (DALYs) lost to various diseases. This approach was designed to enable morbidity and mortality to be compared and therefore allow a rational setting of public health priorities.

The idea behind the DALY is to estimate the proportion of a year that should be attributable to a variety of conditions causing morbidity. If someone dies prematurely, then each year lost counts as one whole DALY. If someone has an illness, such as depression, then each year affected by illness will count as a proportion of a DALY. The controversial and difficult aspect of this method is in estimating the proportion that should be used when calculating DALYs for non-fatal conditions. The first estimates were very subjective, but more recent attempts have been made to base these estimates on a firmer empirical footing [6]. A further limitation concerns the quality of the data on prevalence. Much of the epidemiological information that has been used to estimate the burden of diseases around the world is of questionable reliability, particularly in relation to developing countries, where few large-scale surveys on representative samples have been carried out.

The *World Development Report* and associated publications [7–9] have provided the first estimates that have allowed comparison between depression, other mental disorders and physical illness leading to death. The report estimated that neuropsychiatric disorders led to 8% of the Global Burden of Disease (GBD). For adults aged 15 to 44, mental disorders are estimated to account for 12% of the GBD. Mental disorders are projected to increase to 15% of the GBD and major depression is expected to become second only to ischaemic heart disease in terms of disease burden by the year 2020 [8].

Mental disorders have received little priority in the developing world. Demographic transition and improved measures to combat infectious diseases are leading to a change in the pattern of disease in many poor countries [10]. In Chile, for example, life expectancy is now over 70 years and, along with many other areas of the world, the burden of disease is largely produced by non-communicable diseases familiar to those in the West. These changes will contribute to the growing importance of depression and other mental disorders in world health.

The Global Burden of Disease Study [7] has succeeded in putting depression on the public health map. What has proved more difficult is to persuade policy makers to attend to depression or to encourage research that will lead to a better understanding of the aetiology of depression. Depression is as big a potential public health issue as ischaemic heart disease. For the latter, some major risk factors are well known and preventive strategies can be proposed and are often implemented. In contrast, little is known about the aetiology of depression and in particular there is little evidence for strategies that would lead to primary prevention of depression.

In the following sections of the chapter we shall discuss the influence of globalization on socio-economic status and then gender, and its implications for mental health. In particular, we shall discuss some of the empirical findings in relation to depression and anxiety, as these are the most important psychiatric conditions from the perspective of public health.

SOCIO-ECONOMIC STATUS, GLOBALIZATION AND MENTAL HEALTH

Social Class and Socio-economic Inequalities

Globalization could have an important influence on socio-economic variables both between and within countries. Social class has been one of the key concepts in discussing social stratification within countries. The terminology in this area has been confusing, in health research in particular [11]. We shall use socio-economic status as an overarching concept, though from a sociological perspective it might be better called social class. Marxist sociology has used the term ''social class'' to refer to a social classification based upon ownership. In the UK, social class is usually used to refer to the Registrar General Social Class measure. This is a classification of occupational status in which professional jobs have ''higher'' status than managerial and so on. This classification has proved a useful way of studying differences in health, but it has its limitations. The classification of those out of work, including housewives, raises difficulties. Educational attainment has also been used as an indication of socio-economic status. Income and standard of living are other indicators of socio-economic status. Therefore, occupational status, education, income and standard of living can be thought of as indicators for the overarching sociological concept of socio-economic status. From the perspective of epidemiology, these variables can be studied separately and have different implications for social policy.

In many health studies, standard of living and low income have been confused. Some recent results have also suggested that there is a non-linear relationship between the prevalence of common mental disorders and income, so that most of the association with common mental disorders occurs at low income levels [12]. Low income of course introduces the subject of poverty—a concept that overlaps with socio-economic status but with its own literature and significance.

Measurement of Poverty

There are two main methods of measuring poverty. The conventional approach is based on measures of income (or what economists call consump-

tion expenditure). It is usual for each individual in the household to be attributed the income of the whole household. Net income equals gross income minus direct taxes and an individual is classified as poor if net income falls below a poverty line [13]. Much measurement of income in health studies has ignored the redistributive aspect of taxation. The ''poverty line'' is also an arbitrary concept, though in most developed countries it is linked to those determined by benefit levels. It is also common, at least in Britain, to calculate net incomes after the deduction of housing cost. The idea is to give a better measure of spendable resources. Unstable or uncertain income might also increase financial strain and has been associated with adverse health outcomes [14]. In international comparisons, the World Bank tends to use an income of less than US$2 a day to define poverty.

The second way of defining poverty relies more upon the resources available to a household. Low income may not be a reliable measure of lack of resources, an implication which suggests looking at people's possession of a range of goods and services (or styles or standard of living) directly. This concept is often referred to as deprivation and indicates an ''inability to attain a minimum acceptable way of life in the society''. The pioneer in Britain of this research was Townsend [15].

Townsend used a large number of indicators of goods and services, amenities or participation in activities, but focused on 12 in order to generate summary measures. These included having a refrigerator, an evening out in the last two weeks, a week's holiday away from home in the last year, and a cooked breakfast most days. Perhaps the most important criticism of Townsend was that he took no account of the difference between enforced and chosen lacks. Subsequent work, especially the Breadline Britain surveys [16], have asked people to make this distinction and to state which items/activities constituted necessities in their own view [16]. Several studies have drawn attention to wide differences in deprivation in the same income band. Nolan and Whelan [17] argue for a focus of anti-poverty policy on those counted as poor according to both types of measure.

What is striking about the deprivation approach to defining poverty is that it explicitly defines particular items of household expenditure as ''essentials'' or necessities. Those households without these are defined as poor. There are clearly marked differences between countries and over time in what are regarded as essential items. Poverty, according to this approach, can only be defined in terms of a particular society at a particular point of time and in comparison with other people in that society. If poverty, defined in this way, affects health, it must act via some process that involves comparison between an individual and others.

One of the interesting aspects of globalization is that it might affect these comparisons. In the past, people might have developed norms based upon

standards in their immediate vicinity that were used to guide their view of essentials. In more recent years, the global media industry might influence this process. Perhaps TV "soap operas"—made in Hollywood, London, or Sydney—have become the reference point with which people all over the world compare themselves. In some ways this might make people *feel* poorer, even if the world economy is growing. Globalization is also reducing the extent to which non-monetary activities contribute to the standard of living. Barter and subsistence farming are increasingly replaced by exchanging goods and produce for money.

From an international perspective, the emphasis upon deprivation measures of poverty can seem irrelevant. When such a large proportion of the world are living on less than US$2 a day, arguing about definitions of poverty is perhaps missing the point. Absolute levels of income must be important for the very poorest in the world. Even in the wealthy West, there is evidence that a healthy diet cannot be afforded on welfare benefit levels, at least in the UK [18].

Socio-economic Status and Health

There are well documented socio-economic gradients in mortality and most forms of physical morbidity, though the mechanism of action remains obscure [19–21]. It has been suggested that the socio-economic inequalities exert their influence on physical health via a "psychosocial" route [22, 23]. Mental disorders could have an adverse influence on physical health mediated by hormonal or immunological mechanisms. Studies on mortality have found associations with measures of income or standard of living independent of the associations with occupational status. This is important from a social policy perspective, as changing income inequality is more amenable to changes in social and economic policy than occupational status.

The literature concerning socio-economic status and common mental disorders is more confusing. In part this is because socio-economic status has been measured in a variety of different ways. In the UK there is now good evidence that there is a strong association between low standard of living and the prevalence of common mental disorders. This is independent of Registrar General Social Class and educational attainment. Lewis *et al.* [24], in the Office of Population Censuses and Surveys (OPCS) Psychiatric Morbidity Survey, found an independent association of owning a car and owning rather than renting a home with the prevalence of common mental disorders assessed with the Revised Clinical Interview Schedule (CIS-R) [25]. In the British Household Panel Survey (BHPS), Weich and Lewis [26] found a similar relationship with measures of standard of living when the General Health Questionnaire was used to estimate prevalence.

Such cross-sectional data cannot address two important issues. Firstly, is there an association between socio-economic status and duration of disorder rather than incidence? Data from the BHPS suggest that socio-economic measures appear to delay recovery rather than increase incidence [27]. There is also the possibility that those with poor mental health have a reduced capacity to earn more. This is usually called social selection. Unsurprisingly, there is some evidence for social selection [28–30], but it does not appear to be able to explain the whole socio-economic gradient. There is evidence from the USA that low income is associated with incidence [31].

All the studies referred to above have been conducted in developed countries. Now data are emerging from less developed countries where similar analyses have been undertaken considering the various measurable aspects of socio-economic status. For example, Ludermir and Lewis [32], in a community survey in a poor area of Recife, Brazil, found that years of education were independently associated with prevalence of common mental disorders. In a larger community study in Santiago, Chile, Araya *et al*. [33] have described a similar finding. At present, it is not clear why these studies conducted in Latin American countries should have found different results from those carried out in the UK. There is certainly more variation in the level of education in less developed countries. Is education a more important determinant of life opportunity in the developing world? In a developing country, education might reflect the socio-economic status of the person's own upbringing more accurately than in societies where education is free and compulsory for most of childhood and adolescence. In most Latin American countries a minimum of six years of education is compulsory, though most skilled employment opportunities require a much longer education. In most Latin American countries the state message is that education is the only way to overcome poverty. Therefore, those with less education may feel despondent about their own future. In other words, aspirations of a better future may be more closely linked with your level of education than your current level of income in many developing countries.

These results have supported the hypothesis that socio-economic status is an important factor in determining the prevalence of common mental disorders in the community. Further research will need to put more emphasis on longitudinal studies and begin to work out the possible mechanisms underpinning any link between poverty, education, and mental health. We also need to study differences between countries to try to explain the apparent differences in prevalence. There will of course be important concerns about the possibility that cultural biases could influence results on current measures of psychiatric disorder [34]; however, this should not hinder carrying out such research, but merely lead to caution in drawing conclusions prematurely.

Individual Factors: Financial Strain

One clue that might provide an insight into the mechanisms linking socio-economic status and common mental disorders is provided by data on financial strain. In the BHPS, respondents were asked how they were managing financially. Those who reported difficulty in managing finances had an increased likelihood of being a patient with common mental disorder a year later [27]. In the 1946 birth cohort, a similar finding has been reported, and measure of financial strain was more important than other measures of socio-economic status [35]. When the authors of that study adjusted for financial strain using statistical models, none of their other socio-economic measures were significantly associated with common mental disorders.

Araya *et al*. (unpublished data) also obtained a similar finding in Santiago, Chile. People who reported an income drop in the last six months were more than twice more likely to suffer from a common mental disorder.

There has been little study of the meaning behind the questions about financial strain. It is also striking that financial strain occurs at all levels of income. It is probably not the same as poverty (deprivation) as defined above, though this has not been empirically demonstrated. It is likely that financial strain incorporates an element in which people's own expectations about life have not been met. This could apply as much to those at higher incomes as to those at the bottom. For example, someone with a large mortgage or other commitments might feel under strain to keep up a lifestyle in line with their expectations.

Individual Factors: Life Events

The concept of life events has been an important one in the epidemiology of depression and anxiety [36]. In the UK, George Brown's [37] approach to the measurement of life events has been particularly influential. Research on life events [36] has provided good evidence that environmental stresses increase the risk of developing depression. However, the life events methodology has not led to an understanding of likely mechanisms linking environmental circumstances to psychopathology or to practical preventive strategies. There are probably a number of reasons for this.

The most commonly used method to measure life events in the UK has been the Life Events and Difficulties Schedule (LEDS). It provides a composite measure of life event plus context (i.e., the circumstances of that individual rated by a panel). Brown and colleagues have persuasively argued that the association between life events and depression is much stronger when such ratings of context have been taken into account. Indeed,

one interpretation of the life events literature is that it demonstrates the importance of context in the aetiology of depression. Life events on their own are not that important. One limitation of the methodology that has been adopted is that it is difficult to study the contextual ratings independently. Low socio-economic status is clearly one important element of context that tends to be incorporated in LEDS ratings.

The emphasis on life events has often been misinterpreted in the literature. For example, policy makers have often erroneously regarded the life events literature as supporting the idea that depression is caused by ''acts of God'' and therefore nothing can be done to prevent it through government action [38]. This conclusion, at odds with the real conclusion from George Brown's work, has led to an emphasis on providing social support to those who might experience life events in the hope that this will reduce the possible impact of an adverse occurrence [39]. This ''high risk'' approach has been criticised by epidemiologists and usually has little impact on population rates of illness [40].

Life events research has also led to another major limitation. It has tended to provide a comprehensive summary of all possible environmental stressors. Though different events may well share some common features, an alternative strategy would be to concentrate on one area of environmental stress in order to achieve better understanding of that area. Related to this is the tendency for such studies to be relatively small because of the length and nature of the interviews. This often leads to analyses in which there is a single category of ''severely threatening life events and chronic difficulties''. This classification is very broad and can include deaths, troublesome children or difficulty in paying the bills. The research may show that such a broad categorisation is associated with depression. However, an alternative approach would be to focus on *one* area of environmental stress in more depth. By studying one important aspect of the social environment, future research should be able to come to a better understanding of the likely mechanisms involved. This should in turn lead on to models that could be generalised to other environmental stresses.

Contextual Measures: Social Capital

There has been increasing interest in the possibility that contextual variables, in particular the characteristics of communities or neighbourhoods, can affect health irrespective of the characteristics of the individuals who live in the community [41]. Over recent years this interest has focused on the idea of social capital, defined by Putnam [42] as ''features of social organization, such as networks, norms and trust, that facilitate coordination and cooperation for mutual benefit''. However, the interest in contextual

influences on health is much older and includes broader themes than that of social capital. For example, Durkheim [43] suggested that alienation and anomie were important social influences on the suicide rate. It has been suggested that community influences might be particularly important in influencing common mental disorders.

There has been some research considering physical housing quality [44, 45] and housing type such as high versus low rise in relation to mental health. There has been relatively little interest in the influence of community level or neighbourhood variables on common mental disorders.

A few studies have found that geographical area or neighbourhood is associated with common mental disorders. McCarthy *et al*. [46] concluded that location of housing was more strongly associated than housing type, while Blackman *et al*. [47] compared two housing areas in West Belfast, Northern Ireland, that differed in terms of location, environment and health, but were similar in terms of deprivation levels. Neither of these studies attempted to measure neighbourhood characteristics or used validated assessments of common mental disorders. Macintyre and Ellaway [48] have provided some of the strongest evidence to support a neighbourhood influence on common mental disorders assessed with the 12-item General Health Questionnaire [49]. They found an association between neighbourhood cohesion and mental health, though it was not apparent from their analysis whether this was necessarily a contextual effect.

There is a widespread concern that the amount of social capital is declining. The evidence for this has been amassed in Putnam's recent book *Bowling Alone* [50]. The causes of this are not fully understood, and given the difficulty of operationalizing the measurement of social capital, even the idea that social capital is in decline can be challenged. Naturally, global economic forces have been accused of influencing this possible trend. An increasing emphasis upon individualism goes hand in hand with free market economic theory. Business increasingly assumes that everyone in the community is ''out for himself'' and this attitude might be encouraging individualistic behaviour. The memorable scene from the film *Wall Street* in which the protagonist argues that ''greed is good'' is a popular exposition of this economic approach.

Contextual Measures: Income Inequality

The other contextual measure that has attracted recent attention is the area of inequality of income [51, 52]. Income is of course an individual level variable, or at least at the level of the household. However, income distribution is a contextual measure and can only be thought of in terms of a population. Wilkinson and others have argued that income inequality

within a country is independently associated with mortality, though the overall income or gross domestic product (GDP) per person has little relationship with mortality, at least in the Western market economies. These findings have also been observed in some within-country comparisons. On the basis of these results, Wilkinson [23] has argued that income inequality has a causal influence on mortality, perhaps mediated via a psychosocial route. He has hypothesised that social comparisons between the poor and the rich are sources of stress and can lead to these effects on health.

There has been a great deal of controversy about almost all aspects of the ''income inequality'' hypothesis. One complication is that income distributions cannot be easily described in mathematical terms. As a result, there is a whole family of indices that attempt to describe the income distribution of a population. The gini coefficient is one such measure, but there are also so-called entropy measures as well as simpler statistics that give the proportion of individuals below median or certain percentiles of income [12]. If the relationship between health and income inequality is of importance, there should be a consistent association with all these various measures of income inequality. Finally, many health studies have not taken account of the redistributive aspects of the taxation and benefit system, an important source of between-country variation.

One of the most important limitations of much of this research is that income inequality indices are also related to the number of people on low income within a society [53]. Therefore, the only way to study income inequality itself is to be able to adjust for the influence of individual income and examine for an independent contextual effect of income inequality. Very few of the necessary studies have been carried out on mortality and virtually nothing has been investigated in relation to measures of mental health. A recent US study found that income and income inequalities had independent and significant effects on depression as measured by a self-rated questionnaire, the Center for Epidemiologic Studies Depression Scale (CES-D) [54]. A study in the UK only found evidence for a more complicated interaction between income inequality and individual income. This study used the General Health Questionnaire [12] to measure outcome.

There has been a trend in some countries, including the UK, for an increase in income inequality [55]. It is possible that globalization has contributed to this change, and this implication was certainly used by the UK government to change the taxation system that has exacerbated the problem, at least in the UK. There is, however, an obvious pressure on countries to reduce the burden of welfare provision on companies in order to encourage investment. Current arguments within the European Union, for example, have focused on the different welfare standards set by different governments.

GENDER, GLOBALIZATION AND MENTAL HEALTH

Gender Differences in Prevalence of Common Mental Disorders

''Globalization'' has also resulted in changes in the quality and quantity of the labour force and market. In the developed and developing world, many of the more traditional jobs have been replaced by new sources of employment. More women are working outside the home, leading to changes in the balance of power between men and women [2]. In many parts of the world, women have had to act in a dual role as breadwinners and housekeepers, putting strains on family life.

One of the most robust findings in the psychiatric epidemiology literature is the observation that the prevalence of depression is higher in women than men. This subject has been reviewed on a number of occasions and has led to a considerable debate about the possible causes. A recent WHO publication comprehensively reviewed the literature confirming the consistency of this relationship [56]. For example, the most recent large-scale community surveys carried out in the USA [57], the UK [58] and Australia [59] all found an increased risk of depression and anxiety in women. For example, in the UK data, the odds ratio for women compared with men was 1.76 (95% CI 1.57–1.97) [58] and this association persisted after adjustment for a number of other variables.

A similar pattern has been observed in less developed countries [60, 61]. For instance, in a large household survey of adults in Santiago, Chile, women were more than twice more likely to suffer from a neurotic disorder (OR: 2.37 [1.84–3.07]) [33]. At present, it is not clear whether the gender difference in prevalence of common mental disorders varies between countries. In some more traditional societies and in Mediterranean cultures some authors have found a similar male and female prevalence [56]. However, the possibility of a type 2 error has to be considered in these studies, especially when studying communities with a low prevalence of disorder that will reduce statistical power. It is also not known whether the difference between men and women is a consistent finding in many developing countries. The role of women in developing countries can be very different from that in the developed world and attitudes towards women show great cultural variation even with countries of similar economic development.

The OPCS National Survey of Psychiatric Morbidity has noted that the relationship with gender appeared to vary according to age. In older subjects the prevalence of common mental disorders was no higher in women than men in the UK [62]. In the Chile survey, older men were more likely to show depressive symptoms than women. These may have been chance findings, though the consistency of finding argues against this. This result

has implications for the possible explanations of gender differences, though it cannot on its own argue either for or against hormonal or biological vulnerabilities.

There have also been other reports of no gender difference in prevalence of common mental disorders. These have mainly been when women and men in similar social roles have been compared. For example, Jenkins [63] compared male and female civil servants in the same grade in the British civil service, while Wilhelm *et al*. [64] studied students in Australia. These studies found that there was no difference in prevalence, though the sample sizes were probably rather too small to exclude the possibility of small effects.

Explanations for Difference in Prevalence by Gender

There are a number of possible explanations for the apparent association between gender and the prevalence of depression and anxiety. The main explanations that have been suggested could be classified as follows: response bias, biological and psychological vulnerability, and social role.

Some authors have suggested that there is a response bias such that women are more likely to give a positive response when asked about all symptoms, including those of depression and anxiety. There is evidence that women are more likely than men to report physical symptoms as well as psychological ones, despite the fact that women live longer. A study in Recife, Brazil, also found a bias in that women were more likely to report symptoms on the Symptom-Reporting Questionnaire (SRQ) than on a psychiatric interview, when compared with men [65]. However, even in that study women had a higher prevalence of common mental disorders with the psychiatric interview. It would seem unlikely that response bias could account for the whole observed difference between men and women.

The possibility of some biological or psychological difference between men and women has received the most research. Of interest is the observation that the gender difference between men and women was reduced in those over 55 years of age in the OPCS National Survey of Psychiatric Morbidity [62]. This certainly fits with the idea that the hormonal changes around the menopause might reduce the prevalence of depression in women. Other more social explanations would also fit. Furthermore, it is not clear that this result is consistently found in all datasets.

The final explanation concerns the possibility that gender differences depend upon the different social roles played by men and women. This has been discussed at length, though it is difficult to investigate empirically. The studies of Jenkins [63] and Wilhelm *et al*. [64] are attempting to limit the study to men and women with similar social roles. On average, women have

lower-paid jobs of lower status. It is also difficult to assess unemployment in women, as they are less likely to report they are ''actively seeking work'' than men even if they wish to work. Therefore, studying men and women in similar occupations circumvents those problems. However, there was no measurement in those studies of social roles performed outside paid employment.

More recently, Weich *et al*. [66] have attempted to use data from the BHPS to investigate this issue. The BHPS asked all respondents a number of detailed questions about the tasks performed within the home as well as asking about employment. The General Health Questionnaire was used to assess the prevalence of mental disorder. Weich *et al*. [66] summed the number of roles and found some evidence for the supposition that having either too few roles or too many was associated with common mental disorder. However, this relationship did not explain the difference in prevalence between men and women.

This approach can be criticised as using a very crude method of assessing the degree to which social roles are occupied. From a feminist perspective, men often report carrying out social roles though their objective contribution is less obvious. Women also often take overall responsibility for various tasks within the home such as cooking and shopping as well as childcare. That men occasionally help with these matters might underestimate the need for the woman in the household to manage and organise the tasks.

Globalization and Gender Differences

There has been a change in the place of women in society over recent years. Take, for example, the change in the traditional roles of women and the apparently increased participation of women in the labour force. This change is not always appreciated when inspecting global statistics. For instance, the latest *World Development Report* from the World Bank shows only a marginal increase in female participation in the labour force (39% to 40%) in the last 20 years, although regions such as Latin America showed a 7% increase for that period. However, women who do part-time or occasional jobs might not be considered as part of the labour force, distorting the real composition of that force.

In the UK, for example, as many women are in paid employment as men, though the jobs carried out by women are still less well paid [67]. Women also are more likely to work part-time. This increase in employment rates by women has been accompanied by an increase in the number of two-worker households. This has contributed in quite a major way to the increase in household income inequality in the UK and presumably in other developed

countries [55]. A much larger proportion of households have no earners and have very low income, while a substantial proportion of double-income households are much better off.

It is difficult to know what has influenced these changes. Globalization as a process would be expected to enlarge the size of markets, increase competition and lead to a higher value for scarce resources. Women with skills, it could therefore be argued, would be taken into the workforce at the expense of men without those skills. The tendency for the growth in service industries in developed countries might also have encouraged female employment, as many ''old economy'' manufacturing jobs were traditionally carried out by men.

However, globalization has also meant that a larger and cheaper workforce is needed. Attracting foreign investment usually means relaxing the rules and weakening laws protecting workers. Women and children are used to meet these requirements. In many countries mothers are drawn into the workforce but no facilities are available at which to leave their children, adding to the stress of carrying a triple burden: productive, reproductive, and caring. A mother of five children who wakes before dawn to fix breakfast before going to work in a sweatshop making jeans and then has to cook dinner is unlikely to have energy or time left for anything else. Family and marital problems are left to brew for the coming day. In most countries women are not treated as well as men, and the negative impact of globalization might be more noticeable among women.

Unfortunately, there is a lack of research in this field particularly from less developed countries, partly explained by the heavy emphasis put by agencies on funding only reproductive health research. As a recent paper from Ghana shows [68], women thought their psychosocial problems were the most important and these were connected to heavy workloads, lack of support, financial insecurity, and the care of children. In the context of globalization, the relationship between gender and socio-economic status appears inextricably linked.

CONCLUSIONS

Globalization may well have had and continues to have an important influence on socio-economic and other inequalities within and between countries. There is an increasing acceptance that free market or neo-liberal economic policies will not eradicate poverty within or between countries. One of the important roles of government, one could argue, is to protect their own countries from the full effects of global competition.

There is now good evidence that poverty and poor socio-economic conditions are associated with poorer mental health, as measured by the

prevalence of common mental disorders. There are still some questions, however, about the direction of causation, though current evidence suggests there is an influence both of health on socio-economic status and of socio-economic status on health. Another research agenda concerns the possible mechanisms linking socio-economic status and common mental and physical disorders. At present, the evidence that poverty causes common mental disorders is still not convincing enough to be able to support changes in social and economic policy. As well as carrying out longitudinal studies to establish temporal relationships, studies also need to estimate any likely benefits of changes in income distribution before justifying any changes in social and economic policy. Further research on mechanisms might also indicate which particular policies would have the most impact. The extent to which countries are able to address these issues will depend upon their ability to adjust taxation, benefit and social policies to reduce inequalities or the effect of inequalities. Of most importance will be the political environment. We suspect that changes in economic and social policy will be influenced by political and ideological forces before epidemiological data will have much influence.

In order to address these issues, we will need research both within and between countries and standardization of methodologies to measure both socio-economic indicators and mental symptoms and disorders. There may be important cultural differences in the meaning of socio-economic variables in different settings. Studies from non-Western countries are difficult to find in peer-reviewed journals and this seriously undermines drawing any general conclusions. Studying the differences between men and women and their different social roles is also part of this agenda.

Aside from these scientific concerns, there are overwhelming humanitarian justifications to reduce poverty around the world. The social and economic forces summarised under the heading ‘‘globalization’’ are likely to play an increasingly important part in world health. We have concentrated on the socio-economic aspects of globalization, but there are many other possible influences as well. For example, the easy and rapid spread of infectious diseases illustrates the direct association between ‘‘globalization’’ and health. Today, according to the WHO, 2 million people move between countries every day. It does not take long for a new infectious disease to spread across the world, affecting people from both richer and poorer countries. Infectious diseases might take a more egalitarian perspective than the unequal economic treatment experienced by individuals. However, the potential risk of being infected regardless of one’s wealth or location in the world might eventually help to create the necessary political climate for the most powerful countries to get involved in the fight against world poverty, even if their participation is based only on self-interest.

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CHAPTER

4

The Impact of Legislation on Mental Health Policy

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INTRODUCTION

Legislation is the driving force through which the modern state defines the structures of health care systems and their financial *modus operandi* and systematizes health care standards and programs.

Coupled with the general principles of law, legislation plays another fundamental role: it embodies the binding reference standards, systemic and normative, to which health care providers are accountable. If needed, this allows, through a court of law or an administrative tribunal, enforcement of the specific principles enshrined in the health care system.

The meaning attached to the word ''legislation'' varies from country to country, from culture to culture and, considering linguistic equivalents, even from language to language. The concept of legal instruments covers constitutions, which may include relevant fundamental or programmatic provisions, laws (topical statutes or codes), regulations, orders, decrees, circulars, and directives as well as any binding norms. Court rulings, an important source of law in several countries, have also been considered in an incidental manner.

In the field of mental health care as in other fields, the use of these different types of legal instruments is subject to variations. Yet, some patterns exist as to the types of norm that are embodied in given legal instruments, and the role of modern legal instruments in health care can essentially be broken down into two categories: 1) to describe (define) the structure and operation

of a system aimed at health through preventive, curative and rehabilitative efforts; and 2) to offer a binding (enforceable) set of norms.

The latter (enforceability) has traditionally been the dominating role of legal instruments in the field of health as in other fields; in more concrete terms, a considerable proportion of the existing ''mental health laws'' refers almost exclusively to legal instruments covering involuntary treatment/hospitalization of people with mental disorders. However, with the advent of ever more complex health care systems and human rights' requirements, it is the former (descriptive) that appears to carry contemporary challenges.

A health policy is a set of decisions about the adoption of measures aiming at reaching concrete targets for the improvement of the health situation of a given population [1]. A health policy is usually formulated in broad terms, which are the basis for choosing a strategy, describing in some detail the general lines of action by all interested sectors and agencies, in order to implement the policy.

A policy presupposes a political will which allocates enough resources (financial, human and others) to its execution and determines also its priorities and main lines of action. In general terms, policies are anchored by four guiding principles, namely, access, equity, effectiveness and efficiency. In the mental health field, they reflect the vision of authorities and decision-makers about the areas of promotion, prevention, care and rehabilitation.

LEGAL TRADITIONS AROUND THE WORLD

The legal systems of different jurisdictions—like health policies—are influenced by a number of different legal traditions, themselves derived from prevailing or historical cultural norms and characteristics. The variety of legal facets touched upon by mental health legislation make it a privileged topic for comparative analysis, offering a unique opportunity for analysis on the basis of legal traditions.

Leading comparative law experts divide the law in force around the world into a number of legal families (e.g., common law, Romano-Germanic law, Islamic law, socialist law, Jewish law, Hindu law), some of which are examined here with a view of providing some guidance to readers unfamiliar with this categorization.

In this context, it is relevant to take legal traditions into consideration for a number of reasons. Firstly, it is essential that any legal instrument be understood in its legal context; this is true for substantive law provisions but also for the format of legal instruments. In this respect, the risks inherent in the transposition of legal features from one jurisdiction to another cannot be over-stressed. Secondly, and perhaps most importantly, consideration of legal traditions appears to be essential if discussion to identify areas of

agreement among countries is to occur. This aspect is of enhanced importance in our times, with the world moving further towards regional unions and agreements with common objectives and standards.

Mental health laws are presumed to have similar foundations and influences. However, in many instances, more than one tradition has been influential. Highlights of the main contemporary legal traditions follow, largely drawn from David and Jauffret-Spinosi [2].

Common Law Tradition

The common law family is an influential legal tradition. It emanated from the United Kingdom and has framed the body of law of countries formerly British colonies, including the USA, Canada, India and Pakistan, as well as a number of other countries.

Essentially, this tradition relies largely on judge-made law. The judgement on a case constitutes a legal precedent, i.e., a principle of law to be considered by judges deciding subsequent cases involving similar fact patterns. Statutory provisions may be adopted in the form of an ''act'' by parliament to govern a specific topic, either to regulate a new topic or to summarize existing judge-made law. Such has traditionally been the case for mental health.

The original and continuing authority of judges in this tradition will generally lead them to consider these acts as stating very specific principles to which they may be justified to find exceptions. Legal instruments adopted by parliaments in countries influenced by the common law tradition will tend to be fairly detailed. They will typically attempt to regulate most imaginable situations so as to leave as little ambiguity as possible.

Common law has evolved into different yet related bodies of laws in those countries that have drawn from it. It is common for judges in a number of those countries to draw from precedents and legal principles found in parent common law countries.

With specific regard to mental health, the level of detail provided in acts to describe procedural safeguards is remarkable. In some cases, detailed regulations are adopted to supplement bulky acts. Similarly, detailed provisions spelling out the specific human rights conferred upon persons with mental disorders are recurring.

Civil Law (Romano-Germanic) Tradition

The Romano-Germanic tradition, also designated as the civil law tradition, is another influential legal tradition. It is described as the continuation

of Roman law, from which it has drawn significantly but not exclusively.

In its main contemporary development, it emanated from France and Germany in the 18th and 19th centuries. In France, the *codification* of laws (i.e., the design and introduction of topical codes of laws such as the civil code, the commercial code, etc.) under Napoleon in the early 19th century aimed at systemizing the law so as to make it understandable to every citizen. The subsequent doctrinal work of leading scholars contributed to its clarification and evolution. In Germany, the adoption, in 1900, of the *Bundesgesetzbuch* (BGB), the German civil code, aimed at structuring legal concepts; it resulted from intense work by scholars over the 19th century.

In addition to Continental Europe, where most jurisdictions have been influenced by the Romano-Germanic family, its influence is found in America (e.g., Latin America, Louisiana [USA], Québec [Canada]), in Africa, in the Near East and in Asia.

Essentially, the civil law tradition is based on a codification of customary legal principles. It was initially designed to systemize and organize the law according to theoretical principles. "Codes" are typically divided into a number of topical "books" which embody legal principles of general or specific natures. They are to be considered in relation with each other to assess a legal situation. Codes are designed to be complete. This means that judges very seldom draw from customary law in existence prior to the codification. Judges are to interpret the legal principles contained in the code to decide a given case and they enjoy a significantly lower degree of legal autonomy by comparison with common law judges. Importantly, judges give very great deference to the interpretations and opinions expressed by scholars. Codes from different countries influenced by this family may depart significantly from each other in terms of the rules they embody. Yet, several key legal concepts and theoretical constructs are common to many.

As life in society grew complex over the 19th and 20th centuries, the principles embodied in codes have become less general, more detailed and, hence, less accessible to laypersons. In this sense, the Romano-Germanic family seems to have moved closer to the common law tradition since codification.

As a result of the above, mental health legislation in jurisdictions influenced by the Romano-Germanic family tends to be shorter and contain broader principles. The common meaning of words will matter and definitions of terms will tend to be less frequent, if any at all are used. There may not be detailed and specific human rights provisions in mental health legislation influenced by the Romano-Germanic tradition. Rather, general human rights provisions may be found in constitutional, programmatic or general human rights laws.

Islamic Law Tradition

The influence of the Islamic law tradition is found mainly in countries in the Middle East, Africa and Asia. In contrast with other contemporary legal tradition, it is described as a facet of the religious tradition it draws from: Islam. As such, the impact of the Islamic law tradition on the body of law of a jurisdiction will vary in accordance with the weight that the political authorities give to the religion of Islam. This distinction between Islam-faith and Islam-law explains why few jurisdictions are reportedly governed by Islamic law exclusively.

Essentially, this legal tradition is based on the principles found in sacred writings (Koran and Sunna). These principles are centred on the concepts of obligations and duties, although the concept of rights also exists. Over the years, theologist-jurists (*fouqahâ*) of Islamic law have developed an elaborate set of interpretative writings about the rules of Islamic law, and these carry high authority. In principle, Islamic law governs relations between individuals of the Muslim faith only; followers of other faiths are subjected to different rules. Schools of thought have developed which depart from each other on various aspects of Islamic law, although they agree on the main principles.

Owing to the variety of traditions and societies involved, the bodies of law in force in countries influenced by the Islamic law tradition are, generally speaking, reportedly fairly different from each other.

The mental health laws of countries influenced by the Islamic tradition tend to have also been influenced by another legal tradition. Reports indicate that the influence of Islamic law in the field of mental health is very much present in the *application* of those laws.

Socialist Law Tradition

In keeping with the approach adopted by leading authors, socialist law is understood herein as referring exclusively to the legal tradition emanating from the former Soviet Union (USSR). Varying vestiges of this legal tradition are found in countries which used to be regions of the USSR, including the Russian Federation, Ukraine, Belarus, the Central Asian Republics, the Baltic states and others. They are also found in countries which used to be under the influence of the USSR. The principles found in the socialist law tradition were designed as transitory principles aimed at the creation of a communist society based on fraternity. As such, it is the collective interest, as opposed to the private interest of individuals, that has driven legal enactment.

Most of the countries which formerly composed the USSR are currently in transition from their past status as a region or a satellite of the USSR to their

new status as independent states. It is difficult to appreciate, at this time, the degree of influence, if any at all, that the socialist law tradition has had and will have over the newly independent entities of the former USSR. Leading authors are of the opinion that the jurisdictions involved will follow their own specific legal development, as opposed to adopting common approaches, if only as a manifestation of their newly acquired political autonomy [2]. These developments are likely to be a reflection of the reaction of their current ruling authority towards the existing socialist legal approaches. The influence of the civil law tradition on upcoming reforms is foreseen by some, in view of the historical links and similar structure and concepts of the two traditions.

Other Autonomous Traditions

A number of other important and distinctive legal families and traditions are found around the world, among which are traditions such as those developed in China, India, Japan, Israel and African states.

Finally, it should be said that a very significant portion of societies do not conceive of the law as it is understood in the West or, more simply, reject this way of envisaging society. This may be the case of countries without formal legal instruments and which presumably operate some kind of informal arrangements; the precise knowledge of these informal systems is rather difficult and complex.

RELATIONSHIPS BETWEEN POLICY AND LEGISLATION

Legislation and Mental Health

Perhaps to a significantly larger degree than any other health care field, mental health care is especially dependent on and affected by law. Social interactions of persons with mental disorders have traditionally raised two levels of concern which appear to be foundations for early legal interventions in the field of mental health.

One level is directed at the individuals affected in the first place, i.e., the persons with mental disorders. The very nature of their disorder will frequently make them vulnerable in their contacts with society. This vulnerability typically affects persons with mental disorders in terms of decision-making and behaviour regarding their own health and safety, and in terms of management of their property. Accordingly, legal measures have traditionally been meant to protect persons with mental disorders against themselves by removing a portion of their decision-making and management

authority, and by conferring it upon someone else, to act as a ''best friend''. Typically, these measures have included involuntary hospitalization procedures, substituted consent to treatment procedures and appointment of a legal guardian to manage property.

A second level of concern with persons with mental disorders has historically been directed at family, neighbours, friends and other third parties—i.e., society at large—who interact with a person with a mental disorder. In a significant number of instances, actions and omissions of persons with mental disorders may affect others to the point that their health and safety will be jeopardized. This concern has historically justified lawmakers (herein used in a generic manner to describe any authorities in charge of debating and adopting *legal instruments*) to adopt measures allowing designated authorities to limit the autonomy of persons with mental disorders found to present a danger to the health or safety of others. Traditionally, this was achieved through mandatory (involuntary) hospitalization.

As it can be seen, both levels of concern outlined above have historically rationalized and justified the involuntary hospitalization of persons with mental disorders. It is no surprise therefore that enactments in the field of mental health have typically focused almost exclusively on this topic.

For decades and until recently, the purposes and patterns of legal instruments governing mental health, outlined above, have remained similar. They tended to be conceived as tools allowing societies to react to disturbing or unusual behaviour by persons with mental disorders. Legal instruments were predominantly designed as authority for the removal of persons with mental disorders from the public arena and, typically, for their mandatory seclusion and treatment in large and often remote public psychiatric hospitals. Drafters of those earlier laws tended to consider that the intervention of society was to occur in reaction to unwanted behaviours, as opposed to proactively. This solution was incidentally found to protect the patient's own safety.

The last two decades, however, have witnessed a substantial shift in the pattern of mental health legislation. The origin of this shift, outlined below, dates back to the 1970s and is of a global nature, affecting as it did the priorities of health care as a whole.

In 1977, the World Health Assembly resolved that ''the main social target of governments and the WHO should be the attainment by all the people of the world by the year 2000 of a level of health that would permit them to lead a socially and economically productive life''. In 1978, the World Health Organization (WHO)/United Nations Children's Fund (UNICEF) Alma-Ata International Conference on Primary Health Care [3] affirmed that giving priority to primary health care is the key to attaining this target, and all countries were invited to implement their own strategy accordingly.

In the field of mental health, this primary health care approach led to the development of a widely accepted and advocated new mental health care delivery model. Essentially, the proposed shift in mental health care policy embodied in this new model revolved around five main priority axes:

1. Decentralization of authority.
2. Shift from hospital-based care to community-based care.
3. Active family and community participation.
4. Integration into general health care through delegation to and increased involvement of general non-specialized health care providers.
5. Focus on health promotion and prevention.

In 1990, this new model for mental health care was clearly acknowledged by major international organizations in a declaration [4] adopted in Caracas at the end of a Conference organized by the Pan American Health Organization (PAHO/WHO), and co-sponsored by the World Federation for Mental Health, the World Psychiatric Association, the World Association for Psychosocial Rehabilitation, the Organization of American States' Inter-American Committee on Human Rights, the Latin American Psychiatric Association and the Venezuelan Psychiatric Association, all of which became co-signatories of the final declaration.

In addition, the right of every person with a mental illness to live and work in the community to the extent possible was specifically recognized by the United Nations General Assembly (UNGA) in a key set of 25 principles adopted in 1991 entitled ''Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care'' [5]. The UN Mental Health Principles represent an important and authoritative consensus of nations likely to carry significant weight in framing mental health norms at the international level.

An analysis of the 25 principles demonstrates that they can be grouped in three broad categories, according to their nature:

1. *Political*. In this category the fundamental civil rights of persons with mental disorders are established. It sets up the ''basic rights'': right to health care, to be treated with dignity, to be free of any kind of exploitation or discrimination, and to be declared incapable solely by an independent tribunal. The need of strictly medical parameters to determine mental disorders, the right to confidentiality, the right to privacy, the right to communicate with a third party, the right to have access to one's own records, and the right to religious freedom among others are also included in this category.
2. *Technical*. Under this category are the principles that describe the technical parameters which have to be followed in the care of people with

mental illness. It comprises the right to receive the least restrictive treatment possible, preferably in one's own community; the right to receive appropriate health care, and the use of medication strictly for therapeutic purposes only and never to punish the patient or for the convenience of the staff; the right to an individualized treatment plan, discussed with the patient and revised regularly; the obligation of the staff to register every procedure in the patient's records, making clear whether they were involuntary or not; the need to have informed consent in order to carry out any treatment; the prohibition of sterilization and other irreversible treatment in involuntarily hospitalized patients; and the obligation to maintain a minimum of technical parameters in every psychiatric facility regarding health care, diagnostic and therapeutic instruments available, including medication, and proper professional care.

3. *Judiciary*. In this group of principles the rules which are to be followed in order to carry out involuntary hospitalization, such as the conditions for its use, the external control of this procedure and the process of resorting to judiciary authorities, so that no individual is deprived of freedom without following a legal procedure, are considered. The obligation of informing patients of their own rights and of explaining how to enjoy them should also be considered.

Progressively, a policy aimed at fostering adequate integration into society of persons with mental disorders brought about legislative reforms in a number of jurisdictions and set the tone for similar reforms in other jurisdictions. It is acknowledged that reassessments of budget allocation and the availability of psychopharmacological agents in the standard treatment regimen contributed significantly to the emergence of this policy.

To a large extent, at least on a conceptual basis, this new approach was found to address efficiently the two traditional levels of social concern, outlined earlier, namely, persons with mental disorders and society, while offering a more humane alternative to the individuals involved.

In view of the above, legal instruments governing mental health clearly appear to be in the early part of a transitory phase, moving away from early *reactive* enactments on hospitalization to more *proactive* and comprehensive schemes of legal instruments describing and regulating mental health care integrated into the general health care system.

Recent legislative changes to existing schemes have also included the modernizing of provisions which have traditionally represented the core of legal instruments governing mental health, i.e., mandatory hospitalization procedures. Despite the above-described shift towards a new model, these procedures remain unsurpassed for crisis situations. However, with the increased attention of societies towards respect for fundamental human rights, these traditional measures deserve close attention, as their inherent

interference with individual autonomy carries a potential for human rights infringements.

Increasing Differentiation between Treatment and Hospitalization

Traditionally, provisions governing involuntary hospitalization were typically interpreted as including the authority to treat a person with a mental disorder, even against the patient's will. It went without saying that a hospital stay purported to be therapeutic. In most instances, however, no specific provision makes this explicit.

The single most important legal aspect to notice with regard to treatment is the increasing distinction made by lawmakers and judges between involuntary hospitalization (deprivation of liberty) and involuntary treatment (interference with bodily/mental integrity).

An increased focus on human rights enforcement in the field of mental health care in recent years may explain the emergence of this new dichotomy. It no doubt challenges the traditional assertion that all persons labelled as mentally disordered are unable to understand, appreciate and decide for their own good. It seems to reflect an increasing acceptance of the principle that while persons with mental disorders may occasionally be in a situation where they will be unable to exercise their right to consent or refuse treatment, this will not necessarily be so. Hence, the conclusion that persons with mental disorders are not automatically incompetent for the purpose of deciding about their course of treatment.

Two current trends are noticeable and, although in opposition, both illustrate this differentiation between hospitalization and treatment.

In the first, found in a number of jurisdictions, the authority for the involuntary hospitalization of persons with mental disorders does not include the authority to treat that person. In this context, ''treatment'' encompasses any type of interference with the patient's bodily or mental integrity, such as drug treatment, electroconvulsive therapy and other types of therapy. Measures carried out to limit the autonomy of an aggressive patient in a crisis (emergency) situation, such as the use of physical or chemical constraints, are typically excluded from or constitute an exception to this definition of treatment.

The law in force in the UK illustrates this movement. Another illustration is the law in Canada (Québec), where, under the civil code, a patient's wish not to receive treatment must be respected if care is *categorically* refused, except if purely hygienic or emergency care is involved.

The second manifestation of the increasing differentiation between hospitalization and treatment, quite in opposition to the previous one, is best

illustrated by the legal scheme in force in Italy. Starting with the reform brought about by the 1978 Italian act, treatment, as opposed to hospitalization, is the only mandatory measure that is to be imposed on a patient found to fit legal criteria. In short, apart from exceptional cases, no hospitalization is to take place.

Mental Health Policy and Mental Health Legislation

In an ideal situation, legislation is the formalization or enforcement of a given policy. In practice, however, the situation is far from that ideal. More often than not, mental health legislation predates policies. Policies, being usually related to specific governments, last as long as specific governments, which could be less than the time to have a piece of legislation discussed, adopted and enforced. Moreover, in all too many instances, policies are adopted without due consideration to their implementability, and hence, enforceability by legislation.

On the one hand, as indicated before, a large proportion of current mental health legislation revolves around issues related to involuntary admissions. On the other hand, in so far as mental health policies are concerned, the current greatest debate is—perhaps unduly—the opposition between a mental health care policy based in hospitals and a care centred in the community. The confrontation of these two principles can be seen in the following table.

	Legislation mostly related to admissions	Legislation mostly related to treatment
Hospital-based policy	+	?
Community-based policy	?	+

The + sign indicates those situations in which there is no conflict between policy and legislation, that is, jurisdictions where the legislation is basically related to admissions and the mental health care policy is hospital-based, or where the legislation is more related to treatment and the policy is more community-based. The ? sign indicates conflicting situations, that is, places with a community-based policy in a legal environment dealing mostly with involuntary hospital admissions, or places with a hospital-based policy with legislation dealing mostly with treatment. Admittedly, there are places with hybrid organizations in terms of policy, i.e., large psychiatric hospitals side by side with community agencies providing also beds, irrespective of the kind of legislation.

FROM CONCEPTS TO SERVICE DELIVERY

Mental health systems in many Western countries have their origins in a model that began in Europe with the construction of asylums in the 16th century [6]. This model lasted until the mid-20th century in some industrialized countries, where a deinstitutionalization model began to displace the mental hospitals as the main site for the treatment of the mentally ill; in most developing countries, however, a hospital-based mental health care model prevails and yet in many places the two models coexist. Countries, however, differ, sometimes diametrically, in the application of mental health care despite the fact of upholding one model or the other. The same is true for the legislation related to mental health policy and mental health care.

The following section presents three examples—respectively, from Brazil, Canada and Spain—of the complex relations between legislation and mental health policy.

An Example from Brazil

The situation in Brazil in the field of mental health illustrates not only the disparity between the law and social reality, but also the possibility of the coexistence of different mental health policies in a country. In addition, it exemplifies the clear-cut distinction between what is called *major legislation* (federal and state constitutions, federal, and state laws) and *minor legislation* (decrees, resolutions, and rules).

In democratic countries this distinction is essential, since the comprehensive norms of major legislation—specifically the ones which set out the fundamental rights and the broad ideological guidelines to be followed—can only be implemented through a long and laborious legislative process, which often demands many years before it is adopted and comes into force. Minor norms, however, are generally more quickly adopted; they represent an act of will of the public authority which enacts them, and consequently defines a public policy.

In Brazil, the fundamental rights of people with mental illness, their recognition as human beings with rights and obligations, and the prohibition of discrimination against them have always been maintained by the successive federal constitutions; traditionally, these had a chapter pointing out the individual rights and guarantees. Successive civil laws and civil procedures, mainly from the civil code of 1916 on, have also dealt with the protection of people with mental illness (''mad people of all kinds'', in its terminology), determining the rules of declaration of civil incompetence and the limits of their guardians' power [7]. There is also a specific law,

from 1934 [8], dealing with the ''protection of the person and the properties of psychopaths'' (*psychopath* in this case means ''person with mental disorder'', an effort of the legislation to update the nomenclature of 1916). It not only regulated the issue of involuntary psychiatric admission and some aspects of the declaration of incompetence, but also launched the basis of a comprehensive hospital-based mental health policy for the country.

As Brazil is a federation, besides the federal laws operating all over the country, as exemplified above, each state has the option of adapting its own rules in the field of health. These rules, in turn, can once again be classified in *major* and *minor* rules. Owing to this characteristic of the Brazilian political organization, associated with the country's vast territory and the marked regional socio-economic differences, the establishment throughout the last decades of different mental health policies took place, resulting in various disparate local situations.

In this context, we proceed now to describe how the reform of psychiatric care has been carried out in Brazil and the political forces affecting it.

Before the 1970s, psychiatric care in Brazil was almost completely hospital-based, and generally provided in large psychiatric hospitals (some of them very large indeed, up to 16 000 inpatients). Outpatient psychiatric treatment was almost always of a private nature and its costs were beyond middle-class populations' reach; community-based treatment was hardly known.

That decade witnessed, in the state of Rio Grande do Sul, a slow but effective change in mental health policy that intended to transform the hospital-based model into a community-based one. Before 1970, the main public psychiatric hospital in the state, the century-old Hospital Psiquiátrico São Pedro, located in the capital city of Porto Alegre, looked after 5000 patients, on an asylum basis. The state authorities and decision-makers then in charge initiated an intensive process of transformation, increasing dramatically the number of outpatient facilities (OPCs), mainly in the interior of the state, thus making it possible for many inpatients to return to their communities, and to re-establish and strengthen family ties.

This policy was much reinforced by a pioneering, community-based medical project implemented in an underprivileged area, Vila São José do Murialdo, in Porto Alegre. This project complemented the mental health policy, and as a result, in the late 1980s, the Hospital Psiquiátrico São Pedro had fewer than 1000 patients, with 150 beds for acute patients—whose average length of stay was less than 30 days—and the remaining beds for patients whose families could not be identified or located. In addition, a significant community care system—based on psychiatric OPCs, general medicine OPCs, and protected boarding houses—had been developed all over the state and was fundamental in improving the quality of the

psychiatric services in general. This successful experience—though insufficient, as it is not yet possible to meet the potential demand—confirmed the important fact that a major shift in a mental health care policy was possible with changes in the *minor legislation* only.

This is even more relevant if compared with the attempts to alter the *major legislation* that have been made in Brazil from the late 1980s on. Under the influence of important international political movements, such as the fight for human rights and against the asylums, in 1989, a bill was brought to the attention of the National Parliament; it was essentially based on two important pillars: the closing of all psychiatric hospitals within 5 years of its adoption and the establishment of strict rules and judiciary control of involuntary psychiatric hospitalization, according to Resolution 46/119 of the UNGA on the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991) and the PAHO/WHO Declaration of Caracas (1990), and very close in spirit to Italian Law 180 of 1978. However, this bill is still under discussion, as it became the centre of a strong ideological debate by rival groups in the Congress, and none of them has presented a solid majority either to approve or to reject it*.

Therefore, the national legal norm of 1934 remains in force, with the exception of a few states that have reformed their own legislation. As a consequence, one may find side by side a variety of models of mental health care, such as anachronistic asylum-like mental hospitals, high-quality smaller psychiatric hospitals, psychiatric units in general hospitals, most of them even in teaching hospitals, psychiatric OPCs, day-centres and day-hospitals, and several types of rehabilitation facility. Some of these agencies are well integrated in a mental health care system.

The state of Rio Grande do Sul, possibly because it was already in the vanguard of reform, succeeded in enacting the first state law in the country consistent with the policy of psychiatric reform [9]. Its formulation is similar to the previously mentioned bill submitted to the National Parliament, and once again similar to Italian Law 180: progressive abolition of psychiatric hospitals and the establishment of rules and supervision for involuntary hospitalization.

It is obvious that this paradigm shift did not happen out of the blue in this state, but most probably because of the 30 years of discreet work on minor legislation: the adoption of the new major legislation had a considerable political impact and has been used as a model for the general process of psychiatric reform in Brazil.

The real impact of the new legislation on mental health care in the country as a whole and more particularly in the states which have adopted that new legislation, such as the state of Rio Grande do Sul, remains to be docu-

*Enacted with modifications as Law 10.216 (April 6, 2001).

mented. Nevertheless, having the UN's 25 principles as a model, the following positive aspects can already be observed:

1. In the *political area*: as mentioned above, Brazilian national legislation already protected people with mental illness, in the Constitution and the provisions of the civil code, in the procedure laws and in the legislation in general. However, the new legislation represents a huge support to the anti-stigma movement, strengthening the political clout of consumer and family organizations.
2. Regarding *technical standards* for patient care, a marked improvement may be noticed all over the country. Admittedly, great disparities still persist across regions, and scant medical records, prescriptions repeated monthly without any evaluation, abusive use of medication or of physical restraint, lack of specification on the involuntary records of measures taken, lack of informed consent and a general absence of the basic conditions for a facility to operate are still commonly found. The social contrasts that characterize Brazilian society are also reflected in the health care programmes, as one should expect, and asylums coexist with state-of-the-art facilities affiliated with a university, both funded by public resources and providing services free of charge for the population in general. However, one can perceive a distinct and gradual improvement in mental health care services, mainly in the states which have already undergone a legislation reform. These changes, no doubt, owe a lot to the spirit of the new legislation and to the valorization of a community-based policy.
3. Regarding the *legal guarantees* of freedom of the patient, the UN principles represent an important conceptual change. It is known that the legislation of 1934 had already covered hospitalization in both open and closed psychiatric facilities, leaving the former to voluntary admissions. Voluntary patients could be discharged when they wished. As far as involuntary patients are concerned, "inspecting commissions" had to be set up to supervise the legal aspects of each case and to deliberate also on the necessity of the hospitalization of the patient. The legislation of 1934, however, on account of the changes in the minor legislation and in the social reality, became useless. On the one hand, the administrative organs that would support the inspecting commission no longer existed, and, on the other hand, just one inspecting commission per state had been foreseen, a good reflection of the mental health care policy of the time, strongly hospital-based, and totally inefficient and non-operational nowadays. At present, important transformations can be noticed in those states that have enacted new mental health laws, as the legal concept of involuntary hospitalization has been defined and an immediate notification of its occurrence to the legal authority is required, so that this authority can check the legality of the hospitalization and guarantee the rights of patients.

A Canadian Example

Changes in the delivery of services do not happen without a legal framework that determines what is possible and which becomes a springboard for action. In Canada, stemming from long-established arrangements with the Crown in Britain, health services fall under the jurisdiction of the provinces [10]. The federal government has only regulatory powers through taxation and the transfer of funds for the maintenance of the health system in the provinces, but how services are provided, or organized, are provincial prerogatives [11]. This means that the mental health services and their legislative framework differ from province to province. Already in 1913, the increasing number of inmates and the appalling conditions in the asylums in the province of Ontario eventually led the government of the province to pass an Act Relating to Lunatic Asylums and the Custody of the Insane [12]. Similar legislation was introduced in other provinces without federal input.

In addition, the constitution of the country, *The Canadian Charter of Rights and Freedoms*, enacted in 1982, makes major provisions that affect the way mental health services are delivered as per the rights and freedoms enjoyed by all Canadians [13]. Three sections of the *Charter*—9, 10, and 15—are highly relevant to understand this concept. Section 9 stipulates that nobody can be detained or imprisoned arbitrarily; Section 10 requires that at the moment of detention any person has to be advised about the reasons for the detention, has a right to legal counsel, and a right to *habeas corpus* if so required, and Section 15 clearly outlaws discrimination on grounds of race, ethnic origin, nationality, colour, religion, sex, age, or physical or *mental disorders* (emphasis added). This new conceptualization of civil and human rights demanded that the provinces define clearly and specifically the term ''mental disorder'', identify the parameters for commitment, determine under what conditions a person could be committed and for how long, and establish mechanisms for the protection of patients' rights as identified in the *Charter*. Thus, most provinces have adopted a definition of ''mental disorder'' along lines such as the following:

> A substantial disorder of thinking, affective tone, perceptions, orientation, or memory so that it produces a major disruption of
> (i) judgement
> (ii) behaviour
> (iii) capacity to recognize reality, or
> (iv) capacity to face ordinary demands of life [14].

Furthermore, to commit a person, most provinces use a combination of police power and *parens patriae* clauses requiring that the person who suffers from a ''mental disorder'', as defined above, has to present a danger to self

or others and/or a substantial risk of deterioration and be in need of treatment. To safeguard the rights of patients, every province has an office of the ombudsman and an appeal panel accessible to every patient or their relatives. These panels are independent of the hospital where the patient has been committed and are usually composed of five persons, usually a general practitioner or psychologist, a psychiatrist (not from the hospital), a lawyer, a citizen that represents the public, and a chairperson who is usually a person of importance in the community and who has deep knowledge of mental health legislation.

Legislative fiats in themselves are not sufficient to introduce changes in any system if they are not accompanied by the appropriate budgetary allocations required for their implementation. Unlike general hospitals that traditionally had been organized along local governance and were financed by the municipalities, in Canada, the mental hospitals were operated by the provincial governments. This historical circumstance already created a separation between the community and the hospital, which was compounded by the fact that many of the hospitals had been built in remote areas. Patients sent to these remote facilities, having being taken away from their families and friends, and from their opportunities to continue belonging to their social group and communities, did not know the local people and had no means of integration. On their part, the local community did not feel any interest in their situation other than the financial benefits and jobs that the hospital brought to the community.

The different organizational management, governance, and financing of mental hospitals kept them apart from the changes that were introduced in the general health system of the country in the 1960s. When Medicare was organized and the federal and provincial governments enacted a public health system paid through general taxation, the mental hospitals were not included in as much as they were already financed by the provinces. It took several years before mental hospitals were covered by the new system, but by this time, most mental hospitals had been closed and most patients were already attending and receiving their care in the general hospitals and in the community.

The Canada Health Act [15], a form of Medicare arrangement, is based on five principles which the provinces that are constitutionally in charge of providing health, are supposed to uphold under penalty of federal budgetary repercussions. These are the principles of:

1. Universality—all Canadians are covered.
2. Comprehensiveness—all medical services are covered.
3. Transferability—citizens are covered anywhere in the country.
4. Accessibility—there are no financial barriers to access.
5. Public administration—there is only one payer for all services.

These principles apply to all Canadians regardless of whether their medical problems are physical or mental. The system covers all medical services, from doctors to hospital costs, excluding medications for ambulatory patients. Even the latter are covered through social welfare systems for those patients with limited financial means as is often the case of mental patients.

Still, the transfer of care from the mental hospitals to the community did not happen without trauma, dislocation, and social insensibility. Social situations that affect people with mental illness—including homelessness, criminalization, imprisonment, victimization, poverty, unemployment, and stigma—are attributed to policies of deinstitutionalization that were poorly conceptualized and hastily implemented. Budgetary readjustments have been required in order to meet the financial needs of a mental health system that is now decentralized to the local communities, organized under multiple subsystems, and managed through a myriad of agencies, not just a single mega-institution as in the days of the mental hospitals.

These new structures have required a reconceptualization at the level of governments and communities to organize a system that is patient-focused, integrated, and seamless in the delivery of services. This has also required the development of information systems to facilitate the determination of need for mental health services in the local communities and to provide the bases for financial accountability by the different agencies. Information systems are also expected to provide monitoring tools to measure efficiency in the management of resources and to evaluate the effectiveness of interventions.

New concepts in the provision of mental health services include the development of policies that move away from a concentration on treatment issues and that emphasize prevention of mental conditions, management of their determinants, and promotion of mental health in the population. This new vision underlines initiatives spearheaded by the federal government and its provincial counterparts, but they require community acceptance and public participation [16]. Only through an informed public and visionary government policies can it be expected that mental patients will not be segregated, that they will gain reintegration into the community once they leave the hospital, that they will not suffer stigmatization and discrimination, and that they will feel that their mental condition is not a bar to full participation in the life of their communities [17].

New delivery systems include case management models, community assertive teams, the active participation of patients and their families [18], and outpatient commitment legislation also known as community treatment orders (CTOs). This type of legislation has become controversial, in that it seems to impose legal restrictions on patients and limit their rights, but, properly constructed such as the new Brian's Law in Ontario [19], CTOs

could strike the proper balance between external freedom to act and internal freedom from disease.

A Minimalist Legal Example from Spain

There are four distinct characteristics of the legal context related to people with mental illness in Spain:

1. There is not a specific national mental health law in Spain. A special interdisciplinary commission created ad hoc by the government in the 1980s advised against the establishment of such a law, on grounds of its main inconvenience, namely, the possible discriminations it creates, even though intended to fight them. The advice of the commission was that any specific legal consideration of the needs of people with mental illness should be settled within ordinary legal texts and bodies.
2. The specific rights of the people with mental illness, as well as the type of care they should receive, are regulated, in a non-specific way, together with the rights of other types of patients, by the General Law of Health, of 1986 [20].
3. The specific rights of people with mental illness are also protected in ordinary law, which, on the basis of international agreements, is oriented to the protection of human rights and dignity of human beings in relation to biological and medical interventions [21].
4. The civil code [22] and the Civil Procedure Act [23] regulate involuntary admission to psychiatric units, either at general or at psychiatric hospitals.

With this in mind, let us consider here laws related to involuntary admissions.

The first legal regulation of involuntary psychiatric treatment was legislated in 1931 by the Spanish Republic regime (1931–1936). At the time, it was one of the most advanced laws in Europe. According to it, only a judge could authorize an involuntary psychiatric admission. During Franco's dictatorship (1939–1977) the law was kept without change, and although judicial authorizations gradually became something of a formality, was enough to prevent the political use of psychiatric admissions, as has frequently happened under other dictatorships.

It was not until 1983, six years after democracy had been restored, that a completely revised civil code was introduced, and with it new regulation of involuntary admission on evidence of psychiatric disorders. According to this 1983 regulation (art. 211 of the civil code), the judge remained the key figure, acting as a public guarantor that freedom is not unduly taken from anyone. Consequently, only a judge can authorize an involuntary admission.

Very recently (January 2001), a new law has been introduced: the Civil Procedure Act (*Ley de Enjuiciamiento Civil*), which partially modified the previous norm. However, the central role of the judge has not been changed.

The clinical criteria that justify an involuntary hospitalization have not changed much, but the new law is not very precise in this respect. In practice, any clinical circumstance that strongly requires the provision of treatment under hospital conditions would be sufficient, but the guarantees of the legal procedure have been further developed and strengthened.

The new text (art. 758–763) says: ''The admission due to a *psychological disturbance of a person* who is not able to consent, even if he or she is under guardianship, will need judicial authorization''. It also states: ''Before giving the authorization ... *the court will hear the person* ... and [the judge personally] must examine the *person* ... [and be] acquainted with a medical report''. Finally, the patient can be represented by an attorney and has the right to appeal. Under emergency situations the hospital doctor may decide an involuntary hospitalization, but this decision must be communicated to the court authority within 24 hours.

The initial involuntary hospitalization authorization does not need to specify duration. After the admission, however, the professional in charge (i.e., psychiatrist or psychologist) at the hospital must periodically inform the court about the need to maintain the patient on an involuntary basis. The judge may decide the frequency of the required report, but in any case there must be a report at least than every six months. Anyone may trigger an involuntary hospitalization procedure, but usually the patient's relatives take the initiative.

Since the main role of the court in this procedure is to guarantee patients' rights, patients may be discharged without previous agreement by the judge, but the judge must be informed immediately after the discharge.

In brief, in Spain, since 1931, judges have kept under their responsibility the ability to authorize the admission of psychiatric patients against their will. However, the procedure has changed over time with an evident overall improvement in the protection of patients' rights and full citizenship.

CONCLUSIONS

The relations between the fields of mental health policy and legislation are complex, as both stem from socio-cultural values originating from different sectors in societies, which are not always governed by the same principles, interests and mandates.

The issue of human rights has emerged more recently as one of the governing principles of mental health policy and care, not only in the West, where it originated, but as a universal trend. In addition to it,

the nature of local legal traditions, the distinct implications of major as compared to minor legislation (as discussed above) and the growing importance of the distinction between involuntary treatment (in any setting) and hospitalization (basically as a measure of social control) are currently the most relevant topics to help us understand the complexities of the relations between legislation and mental health policy and care, on a global basis.

Whatever the level of development of both legislation and mental health policy in any jurisdiction or health district, there is plenty of room for improvements in both of them. A closer collaboration between the legal and judicial system, on the one hand, and health policy makers and providers, on the other hand, is fundamental for these improvements to become meaningful for the millions of people with mental disorders worldwide, particularly those who currently have their rights abused, have no access to mental health care and are not under full protection of the law.

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CHAPTER

5

The New Ethical Context of Psychiatry

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INTRODUCTION

The most sacred mission of medicine is the care and the protection of the ill and the infirm. From the beginning of civilization, the intense human nature of medical acts has caused ethics and medicine to be inextricably linked and, since early in history, the doctor–patient relationship has been one of the major power relationships, so much so that doctors were believed to have supernatural powers in some resemblance to divinity. At the beginning of the 21st century, doctors have come a long way from the status of demigods to that of service providers whose prime task and objective is to respond to the needs of their patients in their patients' best interest as appropriate.

Medicine is a healing art and a science. This duality is best reflected in psychiatry, a branch of medicine that specializes in the care and protection of those who are ill and infirm because of a mental condition or disability.

> Psychiatry is a medical discipline concerned with: a) the provision of the best treatment for mental disorders; b) the rehabilitation of individuals suffering from mental illness; and c) the promotion of mental health. Psychiatrists serve patients by providing the best therapy available consistent with accepted scientific knowledge and ethical principles. Psychiatrists should devise therapeutic interventions that are the least restrictive to the freedom of the patient and seek advice in areas of their work about which they do not have primary expertise. While doing so, psychiatrists should be aware of and concerned with the equitable allocation of health resources. [1]

It is only in psychiatry that physicians are expected both to be instrumental in the application of scientific methods to the care of the patient, and to be themselves the instrument of therapy, care and protection. Being an

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instrument of therapy demands a donation of the self unlike anywhere else in medicine.

Furthermore, as a discipline that investigates the brain, and the most obscure and unexplored functions of the brain, psychiatry has a mysticism about it that is not only perceived as such by laypeople but that may, at times, give the psychiatrist a sense of omnipotence that may overshadow the modesty the profession should feel considering the limited amount of knowledge we possess.

The close personal contact required by the psychiatrist–patient relationship is fraught with danger. Boundaries may be transgressed, inadvertently or by design, because of the weakness of either the patient or the therapist. It is the therapist, however, by virtue of being the more powerful in the therapeutic dyad, who is expected to keep clearly in mind, at all times, where the boundaries are, and to abstain from transgression. In this moral duty to respect the boundary, the psychiatrist is assisted by training, by personal convictions, by a respectful reverence for the integrity of the person and of the patient, by deontological canons of conduct personally and professionally developed, and by a cultivated ability to engage in a constant ethical discourse and reasoning about the rights and wrongs of every action on behalf of a patient. Although there may be cultural, social and national differences, these canons of conduct and ethical debates are universal.

Furthermore, the last 40 years have witnessed an advance in medical technology and knowledge that carries with it major hopes for the management of previously incurable ailments. However, it also carries with it several frightening possibilities of abuse.

Mental illness was, and remains, an obscure, frightening category of illness, since it frequently encroaches upon one of the major gifts granted to human beings, the gift of judgment. This distorted judgment of a patient may be a fertile soil for abuse by several power structures, be they political, industrial, administrative or even familial.

It is no wonder, therefore, that several professional and human rights authorities have over the years attempted to develop a series of ethical codes that aim to protect patients from possible abuse by the profession and protect psychiatrists from their own sense of omnipotence.

Ethical implications become more difficult to discern as medical interventions become more complex and as social changes affect more directly the interaction between the physician and the patient, including the specific therapist–patient relationship in psychiatry. Social changes create new ethical dilemmas, new tensions between the physician and the patient and new social expectations from the physician. These dilemmas, tensions and expectations demand an ethical answer from the physician. Psychiatry, as a medical specialty, cannot escape responding, and it responded with a series

of consensus statements and declarations, the last of which was the Madrid Declaration adopted by the World Psychiatric Association (WPA) in 1996. Furthermore, in 1991, the human rights of the mentally ill and their right to treatment were codified for the first time in a United Nations (UN) document, the UN Resolution 46/119 for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (Principles for Policy on Mental Health) [2].

The basic statement in those ethical references is that, despite cultural, social and national differences, the need for ethical conduct and continual review of ethical standards remains universal. It states that, as practitioners of medicine, psychiatrists must be aware of the ethical implications of being physicians, and of the specific ethical demands of the specialty of psychiatry, and that, as members of society, they should balance professional obligations with their responsibilities for the common good.

However, with increasing advances in medicine, the profound secularization in society in general and consequently also in medicine, the increased pluralism with the emergence of a diversity of ideologies, and the increasing emphasis on the need to respect the autonomy of the individual, in addition to the challenging questions put forward by the advancement of science, almost on a daily basis, a general statement is no longer sufficient. New ethical dilemmas require a collective effort from all concerned to draw guidelines that do not sacrifice the interest of the one for the whole, or that of the present for the future. In addressing some of those areas of debate, it may be best to look upon psychiatry from two major angles, which encompass a wide constellation of practices, namely, clinical practice on the one hand and psychiatric research on the other, without overlooking the overlap that frequently exists between the two scopes of practice. Central to both areas of the profession is the issue of patient consent.

THE ISSUE OF CONSENT

What is the purpose of highlighting consent as a core element in psychiatric ethics? The primary purpose is to promote individual autonomy and to allow rational decision-making. It is not the mere signing of a piece of paper to protect the treating physician or institution from future malpractice complaints. Broadly it should involve explaining to the patient the risks and benefits of the proposed treatment and the alternative treatment methods which exist and what the risks and benefits of those treatments are. The patient should be informed of what refusal of treatment would entail in terms of risks and benefits, and one should make sure that the patient is not under some sort of undue influence and that the environment is not coercive. The basic elements of informed consent are competence

(which involves the capacity for decision-making), information (fiduciary relationship which is rooted in respect for the dignity and autonomy of the patient) and non-coercion (note the subtle difference between coercion and persuasion) [3].

The patient should be accepted as a partner by right in the therapeutic process. The therapist–patient relationship must be based on mutual trust and respect to allow the patient to make free and informed decisions. It is the duty of psychiatrists to provide patients with relevant information so as to empower them to come to a rational decision according to personal values and preferences. Common law acknowledges two instances where consent is not needed. The first is cases of necessity, where the doctor is of the opinion that treatment is in the patient's best interest and the patient is not competent to give valid consent to that treatment, and the second is emergency, in order to prevent immediate serious harm to a patient or to others, as to prevent a crime.

> When the patient is incapacitated and unable to exercise proper judgment because of a mental disorder, the psychiatrists should consult with family and, if appropriate, seek legal counsel, to safeguard the human dignity and the legal rights of the patient. No treatment should be provided against the patient's will, unless withholding treatment would endanger the life of the patient and/or those who surround him or her. Treatment must always be in the best interest of the patient. [1]

The shift from dependence on Hippocratic benevolence to reliance upon the paradigm of consent fits well with the evolving of a new moral foundation for doctor–patient relations upon the proposition that persons have rights discernible by reason. The primary purpose of highlighting consent as a core element in psychiatric ethics is to promote individual autonomy and to permit rational decision-making. Although psychiatrists often must accept the responsibility of denying autonomy and dignity rights without the appreciative endorsement of their patients, a clear role definition regarding clinical and social responsibility, valid concepts and assessment procedures to meet legal and clinical standards, and an acceptable degree of predictive validity regarding safety and therapeutic advantages are essential.

However, consent is not the mere signing of a piece of paper by a patient to protect the treating physician or institution from future malpractice complaints. Veatch suggested that the law of informed consent in the treatment area is shamefully inadequate to cope with anything more than a trivial exchange of facts in relation to risk, and points to the notion that there is much beyond the shadow of facts in consent decision-making, referring to the host of values that pertain to the fabric of one's social and political environment [4].

Although the American literature on bioethics frequently dates the birth of the concept of informed consent to the year 1957 (first Supreme Court ruling: informed consent becomes case law), more recent historical research has revealed an earlier medico-ethical debate within the medical profession, the legal profession, and political circles regarding what the doctor was permitted to do with and without the patient's consent. Those debates, taking place towards the end of the 19th century, had already used terms such as ''truth'', ''information'', ''consent'' and ''collaboration in the doctor–patient relationship'', especially in the field of clinical research [5].

Consent mushroomed as an all-pervasive line of defense against the prospects of paternalistic abuse. In a brief period of 20 years, from courtroom to ethics committees, it became a basic assumption that if the conditions of a legal consent were realized, both legal and moral dimensions had satisfied an acceptable threshold of conduct [6]. However, the practical limitations of the informed consent doctrine have now been fully documented by empirical research, which assesses the link, not only to informing the subject but also to subject understanding [7].

Although competence involves the capacity for decision-making, affective incompetence is usually not recognized by law. Appelbaum *et al*. used a new instrument for assessing the capacity of depressed patients to consent to research, in which it was feared that the cognitive effect of the disorder may have impaired the subjects' abilities to protect their interests. The assumption that depressed patients who are assigned to placebo in antidepressant clinical trials are exposed to substantial morbidity and mortality is not based on research data, but such trials are considered unethical [8]. In an analysis of the US Food and Drug Administration data, it was found that the rate of suicide and attempted suicide did not differ between placebo-treated and antidepressant-treated patients. Placebo-treated patients experienced substantial reductions in symptoms. Further research may change attitudes as to whether certain phenomena are ethical or unethical [9].

Informed consent of patients is nowadays a standard and basic ethic in the discourse of medicine and human rights. Before any medical intervention the patients or the persons involved should explicitly express their consent. In order for this consent to be informed, the therapist must inform the patient about the objective, and the benefit as well as the risks of the intervention and any possible alternative interventions. To be able to use this information in an autonomous process of decision-making, patients must have understood the information and must be able to give free consent (i.e., they must be able to make a decision without outside pressure, coercion or manipulation). Patients eligible to consent must be able to apply the understood information to their own personal situation, must be able to identify the consequences of their decision through rational and

sequential thought and must be able to weigh the advantages against the disadvantages of their choice. They should furthermore have a quasi-realistic insight into their personal situation (illness), acknowledge the diagnostic or therapeutic possibilities and reach a decision that they can communicate [10].

The paradigm of consent has, on the whole, served medical ethics well over the past several decades. By linking intervention to the expressed preferences of patients, the requirement of consent, however plastic, has affirmed the dignity and integrity of individuals [11].

RESEARCH

Ethics of Psychiatric Research

> It is the duty of psychiatrists to keep abreast of scientific developments of the specialty and to convey updated knowledge to others. Psychiatrists trained in research should seek to advance the scientific frontiers of psychiatry. [1]

One major area in psychiatry where the issue of consent plays an important role is that of research. For at least the past 50 years, since the issuance of the Nuremberg Code and its accompanying judgments, international law has barred scientific experimentation on human beings without their consent [11].

Several general statements have been made regarding the ethics of psychiatric research, all pertaining to principles that only stress the obvious: research that is not conducted in accordance with the canons of science is unethical. An appropriately constituted ethical committee should approve research activities. Psychiatrists should follow national and international rules for the conduct of research. Only individuals properly trained for research should undertake or direct it. Because psychiatric patients are particularly vulnerable research subjects, extra caution should be taken to safeguard their autonomy as well as their mental and physical integrity. Ethical standards should also be applied in the selection of population groups, in all types of research including epidemiological and sociological studies and in collaborative research involving other disciplines or several investigating centers. And yet it has frequently been established that subjects were unaware that they were participating in experimentation despite the well-known legal requirement [12].

Allars discusses the definition of research. He notes a need for a distinction between different types of research, where the critical distinction should be made between research and clinical practice, which is not research. For example, he calls for identifying the borders between innov-

ation in clinical practice and research. Do the uncertainties of diagnosis and treatment in clinical practice inevitably involve an element of experiment? Since it is very difficult to draw a line between research and clinical practice of medicine, he argues that all clinical practice, innovative and non-innovative, is research [13].

Another issue is the distinction between therapeutic and nontherapeutic research. Therapeutic research is defined as research aimed at improvement in the diagnosis or treatment of a patient or group of patients in the care of the doctor. Nontherapeutic research aims to increase scientific knowledge, irrespective of improving the diagnosis or treatment of any particular patient or patients. The outcome has a potentially wider application than just immediate patient care [14]. This distinction has been criticized by commentators for failure to cater to many types of research that cannot be clearly classified as either therapeutic or nontherapeutic [15]. Moreover, the distinction between direct and indirect beneficial effects on patients is not clear.

The need for guiding principles and the application of strictly enforced ethical and legal requirements are a safeguard for society so that it can in good conscience benefit from the use of cognitively impaired adults as subjects in biomedical experimentation. The Bioethics Declaration of Gijyn states that research on human beings should be carried out after taking into account the freedom of science and respect for human dignity, and that it must get the prior approval of independent ethical committees [16].

Considering the power imbalance between researchers and subjects, it is difficult to consider informed consent as anything more than an open-ended legal mechanism for checking and controlling unsuspected or untrammeled power [17]. Weisstub notes that our research procedures systematically undermine the cognitive capacity of the individuals that would make informed consent meaningful. He argues that the ideal would be for researchers to commit themselves to the prospect of moral relationships occurring between them and subjects in as personal a manner as possible in order to avoid the depersonalization of the research enterprise. But realism about the history of violations of rights and abuses with regard to subjects should lead us to extreme caution in experimenting with the concept of individual, professional, and societal values working in a synchronized relationship. Rather one should continue to emphasize the foreseeable, the need for protection through laying out the level of risk measured against the perceived benefit to be obtained from a positive research outcome in as forthright a manner as possible [6].

McNeill argues that since the representation of the interests of the human participants of research is difficult, the most appropriate people to weigh those different values and reach a decision about whether a particular re-

search program should go ahead or not should be those most affected. The practical solution he suggests is to nominate appropriate knowledgeable people who can represent the interests of potential researchers. He also suggests the extension of the requirement for review beyond medical research to include behavioral, social, anthropological and other fields [18]. Eist recommends that every effort should be made to include researchers, ethicists and community representatives in those review boards to ensure that the rights of research subjects are protected [19]. There is generally a trend toward recognizing the need for a balance of community members (or at least members from outside the medical institution) and members from the research institute. The change should be seen as a part of a more fundamental change happening in society, a change that manifests itself as a distrust of authority, and in particular a distrust of science and research as definers of reality and as instruments for progress. The assumptions of modernism, which put faith in reason and in science (untainted by human weakness), seeing them as above culture, are being called into question.

Genetic Research and Genetic Counseling in Psychiatric Patients

A simplistic view of genetics is inapplicable to mental illness.

> The human genome is the heritage of all humanity and is not patentable as such. A fundamental purpose of assisted reproduction techniques is to medically treat the effects of human infertility and to facilitate procreation if other treatments have proven unsuitable or inefficient. Assisted reproduction techniques may also be used for diagnosing and treating hereditary diseases as well as for authorized research. The production of identical human individuals by cloning should be banned. The use of stem cells for therapeutic purposes should be allowed provided that it does not involve the destruction of embryos. [16]

The development of ethical principles for research on gene therapy is receiving substantial attention at both national and international levels. Current trials in the field of gene therapy represent an increasingly diversified reality as regards both the diseases concerned and the therapeutic paradigms utilized. Analysis of the ethical dimensions and the formulation of regulations must take account of diversity. Internationally, there have been some developments within the framework of the United Nations Educational, Scientific and Cultural Organization (UNESCO) and the European Community. In a recent review, Mauron and Thevoz [20] argued for nonexceptionalism in the regulation of experimental gene therapy. They recommend that the regulation of gene therapies should be consistent

with the standards regulating clinical experimentation in general, notably in such allied fields as experimentation on vaccines and immunobiological products. They point to the risks of gene therapies being treated entirely separately from biomedical research; rather, one should seek to identify the ethical and biosafety dimensions that are specific to these therapies by drawing in extensive interdisciplinary expertise.

Research on the genetic basis of mental disorders is also rapidly increasing and more people suffering from mental illness are participating in such research. Psychiatrists involved in genetic research or counseling should be mindful of the fact that the implication of genetic information is not limited to the individual from whom it was obtained, and that its disclosure can have negative and disruptive effects on the families and communities of the individuals concerned.

Psychiatrists should therefore ensure that people and families who participate in genetic research do so after giving fully informed consent, and that any genetic information in their possession is adequately protected against unauthorized access, misinterpretation or misuse. Care should also be taken in communication with patients and families to make clear that current genetic knowledge is incomplete and may be altered by future findings.

With the increasing pace of research in the genetic basis of mental disorders and the increasing participation of psychiatric patients and their families in genetic research, psychiatrists are under the ethical obligation to follow the guidelines of good practice, and to avoid the risks associated with premature disclosure, misinterpretations or misuse of genetic information. Psychiatrists should not refer patients to genetic testing unless there are satisfactory levels of quality assurance and adequate genetic counseling.

In view of the above, at its 30th session in 1999, UNESCO's General Conference endorsed the Guidelines for the Implementation of the Universal Declaration of the Human Genome and Human Rights drawn up by the International Bioethics Committee and approved by the Intergovernmental Bioethics Committee. The Declaration affirms that in a symbolic sense the human genome is the heritage of humanity and that it underlies the recognition of people's inherent dignity and diversity, and therefore it is imperative not to reduce individuals to their genetic characteristics, and to respect their uniqueness and diversity. It stresses the imperative of rigorous and prior assessment of the potential risks and benefits pertaining to research, treatment or diagnosis affecting an individual's genome and that in all cases free and informed consent of the person concerned should be obtained, in addition to the right of each individual to decide whether or not to be informed of the results of genetic examination. The Declaration proceeds to affirm that no one should be subjected to discrimination based on genetic characteristics [21].

Drug Research and Relationship with the Pharmaceutical Industry

Although most organizations and institutions, including the WPA, have rules and regulations governing their relationship with industry and donors, individual physicians are often involved in interactions with the pharmaceutical industry, or other granting agencies, that could lead to ethical conflict. In their interaction with the pharmaceutical industry or granting agencies, psychiatrists may find themselves in a situation where the interest of the patient runs the risk of coming second to the prime interest of the firm and the trial to support the efficacy of a new therapy. How far a psychiatrist can go in exposing patients to unknown side effects, is still to be determined. To what extent should a psychiatrist expose a patient, previously responding to a type of medication, to a new one under trial, the effect of which is still being tested?

In regard to clinical trials, the welfare of the patient and the most effective treatment to be provided should be placed above any other considerations, be they contractual, academic, or financial. Furthermore, in clinical practice, giving or accepting favors or gifts, whether material or social, should be viewed as unprofessional conduct which makes the physician vulnerable to undue influence by donors or pharmaceutical companies or, in the instance of such transactions with patients or their families, leads to favoritism, breaching the principle that treatment and care should be provided according to need. Moreover, in their relationship with the industry, psychiatrists could be recruited in several ways to forward the interest of the industry (such as participation in advertising, acceptance of tickets for travel to scientific or other related meetings, acceptance of support for service development schemes, and support to public relations of the hospital or other psychiatric services).

However, it is also true that drug research is a very important tool in the development of the art of healing in the psychiatric profession.

It is therefore necessary to stress that the collective duty of the psychiatric profession is to safeguard the welfare of the patients, which is the basic principle that should inform any of the above-mentioned interactions between psychiatrists and industries. Psychiatrists conducting clinical trials have to ensure that their patients have understood all aspects of the informed consent with respect to the trial and the extent of their consent. The level of education or sophistication of the patient is no excuse for bypassing this commitment. They must be cognizant that covert commercial influence on the trial design, promotion of drug trials without scientific value, breach of confidentiality, and restrictive contractual clauses regarding publication of results may each in different ways encroach upon

the freedom of science and scientific information. Psychiatrists conducting clinical trials should be under an obligation to disclose to an independent ethics review board and to their research subjects their financial and contractual obligations and benefits related to the sponsor of the study. Nor should they enroll patients in clinical trials unless this ethics review board has completed a thorough evaluation of the ethics of the project, including the protection of subjects. Furthermore, in the recruitment of patients for drug trials, the overall concern should be the scientific quality of the project. This implies that patients who have responded well to one drug or who are symptom-free should not be involved in other drug trials, and that sequential participation in multiple drug trials may not be in the best interest of the patient. The use of placebo may also be unethical when well-established drugs are available for comparison.

Psychiatrists should be frank with their review boards regarding the terms of reference of the trials they are conducting and therefore the participation in drug trials themselves, and the reimbursement procedures should be explicitly expressed in a policy document of drug companies and included in the informed consent form.

Should a conflict issue arise between the ethical commitment of the psychiatrist to the patients and the trial outcome or the interest of the company, psychiatrists are obliged to insist on the truthful reporting on negative results or unreported adverse effects of psychopharmacological drugs, and agreements to withhold such reporting should not be allowed.

Needless to say, psychiatrists without proper research training should not be allowed to take charge of clinical trials. Their participation in drug trials should be supervised by seniors who are well qualified in research methodology and aware of the ethical guidelines that it involves.

CLINICAL PRACTICE

> Information obtained in the therapeutic relationship should be kept in confidence and used, only and exclusively, for the purpose of improving the mental health of the patient. Psychiatrists are prohibited from making use of such information for personal reasons, or financial or academic benefits. Breach of confidentiality may only be appropriate when serious physical or mental harm to the patient or to a third person would ensue if confidentiality were maintained; in these circumstances, psychiatrists should, whenever possible, first advise the patients about the action to be taken. When psychiatrists are requested to assess a person, it is their duty to inform the person being assessed about the purpose of the intervention, about the use of the findings, and about the possible repercussions of the assessment. This is particularly important when the psychiatrists are involved in third party situations. [1]

Confidentiality

The concept of confidentiality is central to any doctor–patient relationship, but especially in psychiatry where the essence of the relationship is complete disclosure by patients of their innermost motives and intimate areas of life. Yet the clinical setting on many occasions renders the concept very porous to the extent that it is virtually non-existent. Nurses, residents, social workers, psychologists, ward clerks, Medicaid reviewers and accreditation bodies read the patient's chart. So one may say that the great majority of people who see the patient's information do not have any personal interest in or knowledge of the patient and look at their charts in an administrative capacity [22–24].

Furthermore, the computerization of health care information has both positive and negative consequences. The sharing of information between health care professionals has become easier as transmission of data has been simplified. On the other hand, the security measures in place to protect personal information may be lacking. Unauthorized access or disclosure, therefore, becomes a greater concern for patients and may have a chilling effect on the disclosure of information by patients to their health care providers [25–29].

Psychotherapy

Psychotherapy, in the broad sense, is an accepted component of many medical interventions and is an implicit or explicit part of the majority of physician–patient contacts. The specialty of psychotherapy is a complex of activity-related strategies to influence perception and behavior in order to eliminate or reduce mentally induced or associated disorders. It also helps patients to cope with physical illness or psychosocial burdens as well as to prevent illness.

As such, the term ''psychotherapy'' describes in general a field of medical care and specifically a treatment method (a specialty field). Since it is not ethically acceptable to apply procedures of treatment for which there are no specific indications and no evidence of effectiveness and safety, and since medical treatments of any nature should be administered under the provisions of general good practice rules regarding their indications, effectiveness, safety, and quality control, this general rule should apply also to psychotherapy.

In a more specific and restricted sense, psychotherapy comprises techniques involving verbal and non-verbal communication and interaction to achieve specified treatment goals in the care of mental disorders. It belongs to a complex of medical, cultural, spiritual and personal issues; therefore,

the highest ethical behavior of the therapist is to be expected [30]. Because, by definition, psychotherapy engages intimate thoughts, emotions and fantasies, it may evolve into an intense physician–patient relationship. This may result in a situation in which power is unequally shared between therapist and patient, so that the latter may become extremely vulnerable. Psychotherapists should not use such vulnerability to personal advantage or transgress the boundaries established by the professional relationship. This refers not merely to sexual misconduct and abuse of patients by their therapists, but even more to the psychological processes that propel the therapist into the manifold forms of ''emotional exploitation'' and narcissistic abuse [31]. Thus, the general rules that apply to any medical treatment also apply to specific forms of psychotherapy in regard to its indications and outcomes, positive or negative. The risks of psychotherapy are varied and not to be underestimated: psychopathological deterioration, destruction of family relationships, financial burdens, juridical stress, etc. Psychotherapy should therefore be assessed in the same way as any other treatment in psychiatry with regard to criteria of indication, effectiveness, safety and quality control.

Senf argues that the therapeutic task of psychotherapy is the effective treatment and prevention of disorders. This task is fulfilled only when the patient has received a diagnosis and the therapy specifically necessary for that diagnosis, and when there is an adequate relationship between the duration of therapy and outcome [32]. Price is doubtful about some of the propositions of this argument, even if it were clearly an ethical matter. He questions whether patients should be denied psychotherapy if the diagnosis is in doubt and refers to cases where diagnosis does not become clear until psychotherapy is well advanced and the patient is secure enough to confide fully in the therapist [33].

Regarding the combination with other therapies, Sultanov suggests that psychotherapy-pharmacotherapy should be proposed and explained to the patient each time it is medically indicated, and that psychotherapy alone should not be conducted when pharmacotherapy is also necessary for the treatment [34].

Counseling or Psychotherapy?

Scientific psychotherapy as an established method of treatment of illness differs essentially from professional psychological counseling and other forms of ordinary counseling; individual psychological treatment techniques may have their own status within the field of counseling without, however, having a justified claim to be considered psychotherapy. It is therefore necessary to determine definite criteria in the sense of general

principles and obligatory standards with regard to both content and technique as to what is to be considered scientifically supported psychotherapy for the treatment of illness, and what is not. Only in this manner can one stem the growing tendency to refer to any professional psychological counseling as psychotherapy.

Senf identifies psychotherapy as a field of medical care, a method for the treatment of psychiatric disorders, while counseling is devoted mainly to problems of living, such as marital, sexual and family problems. He defines psychotherapy as a professional therapeutic action within the context and according to the rules of the public health system. It is a theoretically deduced and empirically secured setting to bring about goal-oriented changes in the perception and behavior of patients on the basis of well-founded and empirically secured theories on the management of mental disorders, and requires qualified diagnostic methods and differential diagnosis, taking all available methods and procedures into consideration. It should therefore be a method that maintains ethical guidelines and carries out quality control [32].

Who Carries Out Psychotherapy?

In view of the above definition, psychotherapy as a treatment method can only be carried out by professional therapists with recognized training, i.e., only medical doctors and psychologists with a university degree and both long-term theoretical and clinical training in a recognized center for psychotherapy [32]. Price argues that this statement is meaningless and potentially harmful in the absence of a clear definition of psychotherapy. He suggests classifying psychotherapy into the following three broad categories:

1. *Basic psychotherapy*, which should be applied by all medical practitioners as it includes all the techniques for developing a good doctor–patient relationship and ensures that the patient remains in treatment with sufficient confidence in the doctor to take any recommended medication.
2. *General psychotherapy*, which, he suggests, should be used by all psychiatrists and involves helping patients to cope with whatever chaos their lives are in and dealing with whatever factors seem to have precipitated the presenting illness. He recommends that this form of psychotherapy should not take much more than two or three sessions and that it should not be handed over to a nurse or other assistant unless it is clear that a more prolonged therapy is required.

3. *Specialist psychotherapy*, which aims at making fundamental and long-term changes in the patient's way of thinking, feeling and behaving. This form should be carried out by psychiatrists who have had special training over and above the general psychiatric training and who devote the majority of their time to the practice of psychotherapy [33].

An important question asked in that regard by Karasu is how much the definition of therapeutic goals in both psychodynamic and other psychotherapies depends upon the therapist's concept of man [35]. Is it adjustment, optimal adaptation to the social environment as if the meaning of human life were integration with and adjustment to others? Or is it the maximal development of the patient's potential, as if the criteria of a healthy existence were only within the individual human being? [36] With regard to their own values, therapists need to keep their ''ethical countertransference'' under constant observation [37]. In any case, psychotherapists should be particularly sensitive to boundary violations, whether these are of a sexual nature, or for narcissistic, financial, academic or professional gains. Senf also suggests that in order to satisfy the therapeutic task, psychotherapists must be instructed in more than one psychotherapeutic procedure. Training in only one psychotherapeutic procedure increases the risk that patients will not receive the therapy they need. If psychotherapy is seen as a scientific discipline which can be both taught and learned, it must in principle be possible to carry out parallel training, or, after extensive training with the emphasis on one procedure, to proceed to another. However, he argues that the danger of unsystematic eclecticism void of theories on illness and treatment must be considered [32].

As in any other form of therapy, informed consent must be obtained for the application of psychotherapy, particularly such that the benefits and risks are fully understood by the patient. Informing the patient should be part of the initial stage of the therapeutic process. It is also the duty of the psychiatrist to protect patient privacy and confidentiality as part of preserving the healing potential of the doctor–patient relationship. At the initiation of psychotherapy, the patient should be advised that the contents and any materials produced will be kept in confidence, except where the patient gives specific permission (after being well informed of the reasons) or in exceptional circumstances of unavoidable serious risk to a third party from the patient, as in serious child abuse, or serious risk to another or the patient (e.g., cases of potential violence). Patients are also entitled to know of any possibilities of disclosure to third parties: e.g., to paying third parties/insurance companies, to other (supervising) colleagues, or in scientific publications of individual cases.

Involuntary Hospitalization

Psychiatry accepts the clinical responsibility of determining which individuals, on the basis of mental disease and the law, shall be deprived of autonomy rights by involuntary commitment to receive protection and perhaps treatment through clinical services. This burden of judgment and responsibility weighs heavily on the physician–patient relationship and on the professional identity of the physician. Psychiatrists perceive their discipline as being at risk when their assertion of this authority is criticized by society and by the patient whose autonomy rights are compromised.

The Steering Committee on Bioethics (CDBI) of the European Community stated that deprival of liberty as a result of involuntary placement or administration of an involuntary treatment should always be accompanied by procedures to protect the rights of the person concerned [38]. Criteria for such involuntary placement involve the existence of a mental disorder which represents a serious danger to the person concerned, including to his/her health, and/or a serious danger to other persons (provided that the placement or the treatment or both are likely to be beneficial to the person concerned in all cases).

The CDBI stated that the patient must be examined by a psychiatrist or other medical doctor and the decision for involuntary placement should be confirmed by a relevant independent authority, which should base its decision on valid and reliable standards of medical expertise. The committee, however, distinguished between involuntary placement and involuntary treatment, where the latter does not necessarily follow from the former. It stated that a distinction should be made between the legal ground for involuntary placement and the legal ground for involuntary treatment; i.e., involuntary admission as such does not mean that patients can in any event be treated against their will, nor that involuntary treatment should inevitably require involuntary placement.

The UN resolution on the rights of mental patients, issued in 1991, states that involuntary admission or a voluntary patient's being retained as involuntary shall occur only if a qualified psychiatrist authorized by law for that purpose determines that that person has a mental illness and considers that there is a serious likelihood of immediate or imminent harm to that person or other persons, or that failure to admit and treat may lead to serious deterioration of that patient's condition. A second opinion should be obtained where possible and if the second opinion is not in agreement, involuntary admission or retention should not take place. It also states that a mental health facility may receive involuntary patients only if the facility has been designated to do so by a competent authority. Once involuntary admission has taken place, a review body, consisting of one or more independent psychiatrists, should periodically review the case to consider whether the criteria for involuntary

admission are satisfied. The resolution also states that an involuntary patient can apply to a review body for release or voluntary status.

In reality, the distinction between voluntary and involuntary admission is not as clear as stated in the law. Patients are often induced or pressured into accepting voluntary admission. If voluntary admission were to be maintained as truly voluntary, involuntary admissions would be likely to increase. The family role is strong in ''enforcing'' voluntary admissions in traditional societies, which have no need for involuntary admissions. In traditional societies respect for and obedience to family decisions exceed the autonomy of the individual in importance. Gardener *et al*. reported that an influential rationale for involuntary hospitalization is that prospective patients who refuse hospitalization at the time it is offered are likely to change their belief about the necessity of hospitalization after receiving hospital treatment [39]. Many patients who initially judged that they did not need hospitalization revised their belief after hospital discharge, and admitted that they had needed hospital treatment. However, perceptions of coercion were stable from admission to follow-up, and patients' attitudes toward hospitalization did not become more positive. Coerced patients did not appear to be grateful for the experience of hospitalization, even if they later concluded that they had needed it.

Euthanasia

The ethical question of physician-assisted suicide continues to be an issue of controversy, such suicide being strongly opposed by some organizations, e.g., the WPA, the American Medical Association (AMA) and the American Psychiatric Association (APA), and equally strongly supported by others. Many concerns have been raised about the inexact standards for determining which patients are truly terminally ill and at the end of life. In addition, questions have been raised about whether physician-assisted suicide requests are truly those of the patient or those of caretakers who may understandably wish to be relieved of their care burdens.

The Bioethics Declaration of Gijyn recommends that the ethical debate on end-of-life issues should be continued in order to analyze in depth the different ethical and cultural conceptions in this context and in order to assess the way to their harmonization [16].

Although laws may allow physician-assisted suicide in the future, the place of psychiatrists would most likely be in assessing competence and the presence or absence of a psychiatric illness influencing the patient's decisions. The Madrid Declaration stresses that the physician's duty is, first and foremost, the promotion of health, the reduction of suffering, and the protection of life. The psychiatrist, among whose patients may be some who

are severely incapacitated and incompetent to reach a decision, should be particularly careful of actions that could lead to the death of those who cannot protect themselves because of their disability. The psychiatrist should be aware that the views of a patient might be distorted by mental illness such as depression. In such situations, the psychiatrist's role is to treat the illness.

Ethical Questions Arising from Managed Care Systems

The UN Resolution 46/119 for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care calls upon all national governments to adopt appropriate legislative, juridical, administrative, educative and other provisions to ensure the right of every human being to the best mental health care available, stated as the ''right to receive such health and social care as is appropriate to his or her health needs'' (principle VIII) [2]. The implication of that principle is that this human right will be violated in all places where the best possible care is not available, as through lack of financial or organizational/administrative resources. Therefore, the authorities are obliged to try to overcome this lack in order to provide the best possible therapy according to the most developed psychiatric knowledge, experience, and technique.

These problems of resource allocation, which are currently growing rapidly worldwide, as well as new challenges through progress in research, led the WPA to make the guidelines more specific. Probably the greatest challenge as we move into the 21st century will continue to be the changing economic influences in psychiatric treatment as well as the business focus in patient care. The business focus has often created a dilemma for the psychiatrist as both clinician and administrator, or clinician and stockholder. If psychiatric ethics move to more of a business ethic, the traditional covenant of trust between doctor and patient may be irrevocably shattered. It would mean moving from that covenant to a corporate ethic of doing the least for your customers without dissatisfying them [40, 41].

Current market forces are demanding high-quality health care with improved access and at the lowest possible cost. In addition, there is a new emphasis on accountability both to the payers of insurance and to the public. With regard to the issue of providing quality care at the lowest possible cost, there are considerable pitfalls in the marketplace. The current competitive nature of psychiatric care is driving down the amount of funds that payers are providing for psychiatric and substance abuse treatment. This is especially true in mature managed care markets using capitation as a form of payment. Unfortunately, capitation rates continue to fall while comprehensive psychiatric services are being promised. This leaves many

to wonder whether there is honest disclosure of what will be provided and the real limitations once capitation rates have fallen significantly. Some ethicists see no more peril in managed systems of care than in fee-for-service systems [42].

The influence of managed care and third-party payers in mental health services has changed not only the doctor–patient relationship, but also the disclosure of information.

The obligations of managed care organizations toward shareholders regarding maximization of profits and minimization of costs may conflict with the principles of good clinical practice. Psychiatrists working in managed care organizations should uphold the needs of the patients and the rights of the patient to the best treatment possible above considerations of cost or organizational demands.

In agreement with UN Resolution 46/119, psychiatrists should not implement policies directed against parity of benefits and other entitlements and should desist from work under conditions of discrimination against the mentally ill (e.g., parity and entitlements) or against any other group of patients.

In the field of psychiatry, practitioners should uphold the well-being of their patients above considerations of expenditure to save costs. However, while professional independence to apply best practice guidelines and upholding the welfare of the patient should be the primary considerations for a psychiatrist working in or out of managed care organizations, it is also true that working for them entails a commitment to the profit-making of those organizations. It is also the duty of the psychiatrist to protect patient privacy and confidentiality as part of preserving the healing potential of the doctor–patient relationship.

Unless managed care is a component of a general health policy based on equity and access to services, it will be an obstacle to patients' proper management opportunities. Because of the diversity, not only of mental patients, but also of the mental illnesses they have, mental patients within the present privately based insurance system may suffer from discrimination due to lack of parity with other medical conditions.

Psychiatrists should be aware of mental health care policies and systems that discriminate against mental patients, should oppose those policies against parity of benefits and other entitlements, and should refuse to work under conditions of discrimination against any group of patients in any way. They should oppose discriminatory practices against mental patients that limit their benefits and entitlements, curb the scope of treatment or restrict their access to proper medications. In that context it would be unethical for psychiatrists to collaborate with any form of mental health care service that varies from the existing consensus guidelines for ethical and quality standards in the treatment of mental disorders.

Torture and the Death Penalty

The Declaration of Hawaii, prepared by Clarence Blomquist and adopted by the General Assembly of the WPA in Hawaii in 1977, was the first position statement of the psychiatric profession aiming to encourage psychiatrists in conflicts of loyalty in contemporary societies and to help them in conflicts of psychiatric decision-making. A major trigger was the political misuse of psychiatry in countries such as Nazi Germany, the former Soviet Union, Romania, and South Africa that came to public awareness during the early 1970s. The rationale for physicians to be a state tool against individuals recognized by the state as enemies is reminiscent of how German physicians justified their involvement in the torture and killing of thousands of innocent human beings and carried out the Nazi programs of sterilization and ''euthanasia'' by murdering countless children and adults.

The very first paragraph of the Declaration is concerned with the ethical problem of the political misuse of psychiatric concepts, knowledge and techniques, stating that the psychiatrist shall serve the best interests of the patient and treat every patient with the solicitude and respect due to the dignity of all human beings, and that psychiatrists must refuse to cooperate if some third party demands actions contrary to ethical principles [43]. Other ethical statements have underlined the same principles. The UN Principles of Medical Ethics (1982) states in its second principle that it is a gross contravention of medical ethics as well as an offense under applicable international instruments for health personnel, particularly physicians, to engage actively or passively in acts which constitute participation in, complicity in, incitement to or attempts to inflict torture or other cruel, inhuman or degrading treatment or punishment [44]. The WPA Declaration on the Participation of Psychiatrists in the Death Penalty states that psychiatrists are physicians and must adhere to the Hippocratic oath; they must practice for the good of their patients and never do harm [45]. They should therefore refuse to enter into any relationship with prisoners other than one directed at evaluating, protecting or improving their physical and mental health. The Madrid Declaration (1996) states clearly that a psychiatrist should not take part in any process of mental or physical torture, even when authorities attempt to force their involvement in such acts [1].

While those statements seem to be stressing the obvious, considering psychiatrists' commitment to the well-being of their patients, the issue has not been without controversy, especially when it comes to the death penalty. Appelbaum argues that a forensic psychiatrist in truth does not act as a physician: ''If the essence of the physician's role is to promote healing and/or to relieve suffering, it is apparent that the forensic psychiatrist operates outside the scope of that role. Were we to call such a person a forensicist or some similar appellation, it might more easily be apparent that a different

non-medical role with its own ethical values is involved'' [46]. In response, a joint monograph issued by the American College of Physicians, Human Rights Watch, Physicians for Human Rights and the National Coalition to Abolish the Death Penalty objects that ''this claim ignores the reality that forensic practitioners . . . are physicians in the eyes of the public, the courts and even their examinees. Equally worrisome is the open-endedness of the claim that forensic physicians do not function as doctors.''

Psychiatrists may indeed be torn between traditional ethical principles and strong pressures from society, particularly certain segments of the legal profession, to compromise ethically and become collaborators with the demands of the law [47].

Freedman and Halpern argue that rather than look for compromises, psychiatrists must return to traditional concepts of medicine and psychiatry as a profession of care, compassion and healing. They should join in the struggle to uphold ethical and moral principles, or they will reap a whirlwind of public condemnation [48].

RELATIONSHIP WITH THE MEDIA

Over the past years, it has been within the mandate of the WPA, its member societies and the APA to erase the stigma against mentally ill subjects. While the tools for undertaking this mission certainly include conveying correct informative messages and educational material to both patients and their families, psychiatrists also have an obligation to create a public understanding of mental illness, acceptance of the mentally ill and rejection of social or other forms of discrimination based on mental illness. Major steps have been taken internationally in that respect regarding physical disability. However, the social attitude toward mental disability has not followed at the same pace. One important tool in this aspect is the mass media.

The media has a key role in shaping the perceptions and attitudes of the community, and an important role of psychiatrists is to advocate those people who suffer from mental disorders. Affirmative use of the media by psychiatrists is important for a variety of goals of good mental health care, for the destigmatization of mental disorder and that of mental patients. In all interactions with the media, the primary role of psychiatrists is to be advocates of the mentally ill and to maintain the dignity of the profession. They should be mindful of the effect of their statements on the public perception of the profession and patients, and abstain from making statements or undertaking public activities that may be demeaning to either.

Psychiatrists should ensure that people with mental illness are presented in a manner which preserves their dignity and privacy, and which reduces stigma and discrimination against them. As the public perception of

psychiatrists and psychiatry reflects on patients, psychiatrists should represent the profession of psychiatry with dignity. In presenting research findings to the media, psychiatrists should ensure the scientific integrity of the information given and be mindful of the potential impact of their statements on the public perception of mental illness and on the welfare of people with mental disorders.

Particularly, psychiatrists should not become involved in sensational reporting or publicity in the media. They should not make pronouncements to the media about the presumed psychopathology of third parties, including public figures, persons involved in judicial procedures, or others.

ETHICS AND CULTURE

The development of ethical declarations is unfortunately not the end of the story. Human rights conventions all over the world assume a social and political system where the individual being is the center of social attention. The Madrid Declaration, no exception to other declarations, assumes a society where the individual is the focus, where the individual is in charge. What if this is not the case everywhere in the world?

Cultural, ethnic and sometimes socio-demographic data such as level of education, age and sex suggest different attitudes regarding patient autonomy and informed consent. What is the perceived harm when members of the medical community violate cultural conventions and insist on telling the truth to the patient? What are the disruptions of coping mechanisms of individuals and families? In what ways does acculturation change the beliefs of patients of various ethnicities? Whether we like it or not, the encounters between psychiatry and the law keep bringing us back to our conflicting conceptions of the value of health, on the one hand, and the value of liberty, integrity and autonomy, on the other hand.

We believe that implementation of codes of ethics is frequently difficult because of the cultural and social systems in which the attempts at implementation are being made. These difficulties stem not only from interactions between individuals, families, and the community but also from the social position of the medical doctor and the hierarchical structure of the medical profession vis-à-vis the rest of the community. Religion and other beliefs also have an effect on the lives and behavior of people. The Madrid Declaration addresses cultural sensitivity: for example, in Eastern cultures, social integration is emphasized more than autonomy; that is, the family, not the individual, is the unit of society. Dependence is more natural and infirmity is less alien in these cultures. When affiliation is more important than achievement, how one appears to others becomes vital, and shame, rather than guilt, becomes a driving force. In the same manner, physical illness and

somatic manifestations of psychological distress become more understood and acceptable and evoke a caring response. In some traditional cultures the collectivity of the community is valued rather than the individuality of its members. Decisions are made not at an individual level but on a familial, tribal or communal level, in the best perceived collective interest.

The belief in the universality of implementing similar ethical codes in all cultures and societies is a mirage. Informed consent, involuntary admission and confidentiality are not so empowering in some traditional and Eastern societies, representing two-thirds of the world's population. Autonomy versus family-centered decision is one of the main areas of difference between Western and Eastern societies. How can we adhere to our ethical guidelines and at the same time not disregard the local values and norms of our target population? How can we practice without showing disrespect or disregard for local values? On the other hand, how can we ensure that respect for the local culture does not become a pretext for bypassing ethical guidelines, to the detriment of patients' rights?

Whether we like it or not, the encounter of psychiatry and law keeps bringing us back to the duality that exists between our conflicting conceptions of the value of health, on the one hand, and our conception of liberty, integrity and autonomy, on the other hand.

To understand this pattern, one has to be familiar with the main characteristics that distinguish the positions of individuals within their community in a traditional society from those in a Western society. Although societies should not be taken as stereotypes, general common attitudes may be assumed [37].

The comparison set out in Table 5.1 is a very crude contrast to highlight the main differences. However, it should be noted that those differences are the mainstream norm and not an absolute description of stereotyped behavior [49, 50].

What if the decision-making process is not an individual one? Arab cultures, for example, deal with issues of illness as a family matter. Whether or not a patient is hospitalized, subject to electroconvulsive therapy, kept or discharged from hospital is not dependent on what the patient personally wants but on the estimation/need/wish of the family, both nuclear and extended. Patients may, at times, wish not to be burdened with the extra load of having to take a decision that may determine the pattern of the rest of their lives. The concept of shared responsibility is central in Arab culture and the majority would not like to be responsible for the outcome of an individual decision.

The decision-making style might be best described in Eastern cultures as family centered. The moral, social and psychological support for which extended families in the Third World are so famous is a largely conditioned process. It is conditioned by the collectivity of decision-making,

TABLE 5.1 Main differences concerning the positions of individuals within their community in a traditional vs. a Western society

Traditional society	Western society
Family and group oriented	Individual oriented
Extended family (not so geographical as before, but conceptual)	Nuclear family
Status determined by age and position in the family; care of elderly	Status achieved by own efforts
Relationship between kin obligatory	Relationship between kin determined by individual choice
Arranged marriages with an element of choice dependent on interfamilial relationship	Choice of marital partner determined by interpersonal relationship
Extensive knowledge of distant relatives	Knowledge restricted to close relatives
Decision-making dependent on the family	Autonomy of individual
Locus of control external	Locus of control internal
Respect and reverence for the decision of the physician	Doubt in doctor–patient relationship
Malpractice suing rare	Malpractice suing common
Deference is God ordained	Deference is self-determined
Doctor–patient relationship is still healthy	Mistrust is not uncommon
Individuals can be replaced; the family must continue and pride is in the family tie	Individual is irreplaceable, self-pride
Pride in family care for the mental patient	Community is responsible
Dependence on God in health and disease, attribution of illness and recovery to God's will	Self-determined

by consensus. An individual decision not in agreement with the collective leaves decision-makers alone in bearing the responsibility of the outcome and may deprive them of familial support. This is not necessarily perceived as a negative value or pattern of relationships, but is the norm of personal interaction within families, especially if the family will be sharing the consequences of the decision. The negative consequences of the decision are then not the patient's fault alone and the patient does not have to bear the guilt of making a wrong decision.

An example of the issue of consent and decision-making may be that of hospital admission. Voluntary admission makes up approximately 73% of psychiatric hospitalizations in the USA; in Egypt it is 90% [10]. In the Middle East, respect for and obedience to family decisions exceed in importance the

autonomy of the individual, especially if the burden of an outpatient will lie entirely on the family, in the absence of community social support systems.

However, it is the responsibility of the family to hear bad news about diagnosis and prognosis and to make difficult decisions. Comparison of Italy, Greece, Spain and Egypt regarding the issue of revealing a diagnosis of cancer shows that autonomy is not viewed as empowering. Rather it is seen as isolating and burdensome to patients who are suffering too much or too ignorant about their condition to be able to make meaningful choices. It may be considered harmful to the patients, causing them to lose hope.

Affiliation versus Autonomy

The attitude toward decision-making just discussed indicates a social value system where autonomy is not the center of concern. The idea of patient autonomy is not universal. In the USA 90% of physicians did not inform their patients of the diagnosis of cancer in 1961. This was reversed in 1979 when 97% of physicians made it their policy to inform patients with cancer of their diagnosis. Most of the literature that discusses this change views it as a simple progress from an unquestioning paternalism to a more enlightened and respectful attitude toward the patient. The same can be applied to mental illness, with a major difference being the lack of stigma associated with cancer. Cultural, ethnic and probably socio-demographic factors suggest different attitudes toward patient autonomy and informed consent. Sharing the European-American model is subject to the process of acculturation. For those who follow the family-centered model, a higher value may be placed on the harmonious functioning of the family than on the autonomy of its individual members. Although the patient autonomy model is founded on the idea of respect for persons, people live, get sick, and die while embedded in the context of family and culture and inevitably exist not simply as individuals but as part of a web of relationships [51].

Ironically, insisting on the patient autonomy model of medical decision-making, when that model runs counter to the deepest values of the patient, may be another form of the paternalistic idea that "doctor knows best". People in the Middle East may actually dismiss doctors because of the way they convey information to the patient or if they make the patient their only reference point in making decisions.

Confidentiality

The relativity of consent and autonomy feed back into a third major element of psychiatric ethics, that of confidentiality and disclosure of information,

which is another universal principle of the Madrid and other professional declarations. Although there exists no consistently accepted set of information to be disclosed for any given medical or psychiatric situation, as a rule of thumb, five areas of information are generally provided: diagnosis; nature and purpose of the proposed treatment; consequences, risks, and benefits of the proposed treatment; viable alternatives to the proposed treatment; and prognosis, that is, the projected outcome with and without treatment.

Telling patients the truth about their condition, especially in cases where the prognosis is bad or a major decision should be taken, is not considered a virtue in Arab culture. In fact, Arab families, although praising the technological advance of medicine ''abroad'', would always comment about the harshness of Western doctors, who tell their patients the truth frankly and without consideration of the emotional trauma that this might entail. In Arab culture, the norm is to tell the family first, and it is almost entirely left to the family to decide whether or not to convey the information to the patient [50].

Traditional families frequently speak of their cousin who ''feels'' that he or she may have cancer and ''who does not really want to know for sure''. There is a strong conviction among Middle Eastern patients that not knowing the bad truth provides the patient with a hope that things may get better. Issues like preparation for death, or preparing a will or other economic arrangements are hardly a matter of concern, probably because those matters are dictated by Islamic jurisprudence with little space for interference from the patient. Preparation for death is mainly a spiritual matter with few practical implications. In the field of psychiatry, patients and their families always like to hear that the condition will improve. Even if it does not improve, or improves only for short periods, they would rather consult a psychiatrist who insists ''that things will get better'' than one who gives the outcome in statistical, scientifically based figures, even if the two were prescribing the same medication. Arabs tend to believe that recovery is the outcome of God's will, while no recovery may indicate the doctor's failure.

It is true that the more the international input in the drafting of a declaration, the more it can consider all difficulties, but in the end the world needs a document that highlights the major principles. We argue that the implementation of codes of ethics is frequently challenged by the cultural and social systems in which they are implemented. These challenges are limited not only by the interaction of individual versus family versus community or tribe alone but also by the social position of the medical doctor and the hierarchical structure of the medical profession vis-à-vis the rest of the community, in addition to the role played by religion and other beliefs in coloring the lives and behavior of people.

We would like to stress that we are not putting forward those patterns of interaction in order to bypass the implementation of ethical codes in any given culture. It is still our primary mandate to secure an ethical foundation for our practice and not to leave our patients at the mercy of the good intentions of the practitioner. This chapter only proposes that the implementation of ethical codes needs tact and understanding of the local constraints in order not to further jeopardize the ill-defined image of the psychiatrist and the specialty of psychiatry. We could, for example, suggest that physicians ask patients whether they wish to be informed about their illness and be involved in making decisions about their care, or whether they prefer that their family handles such matters. We would thereby be approaching the issue of consent in a broader framework than on the concrete day-to-day information. In any case, the patient's wishes should be respected. Allowing patients to choose a family-centered decision-making style does not mean abandoning our commitment to individual autonomy or its legal expression in the doctrine of informed consent. Rather, it means broadening our view of autonomy so that respect for persons includes respect for the cultural values which they bring with them to the decision-making process.

CONCLUSIONS

The predominant trend that is identified in this chapter is that toward a view of science and research as negotiated perspectives between different possible views in society. Ethical review is ultimately a weighing of values and a part of negotiation for a better life. Necessarily, this must take into account the different views of what constitutes the good life in our increasingly multicultural societies. The people to weigh those different values and decide whether a particular research program or clinical practice should go ahead or not should be those most affected. This is the ethical view of the postmodern world. While the predominance of science has been challenged before, postmodernism makes it easier to recognize that there is a trend away from accepting any view of reality as sacrosanct, including those constructed by scientists. Increasingly, the ethics of research, clinical practice and everyday life will depend on negotiation. Stripped of the certainties of the past, we have to take responsibility for reconstructing the world and finding perspectives we can live with. This is a communal and political activity, in the broadest sense. This model of representative decision-making, along with effective communication, has the potential to accommodate the many ideals, values, beliefs and dreams we have as human beings [18].

Yet, neither deontological rules, nor teachings of ethics, nor examples from our leaders, nor rule of law, will support the desired effect of practicing

psychiatry ethically if the individual practitioner is not imbued with a deep sense of responsibility toward the patient and a clear judgment to discern the correct and appropriate behavior at any given time. Because, in the seclusion of the clinical setting, only the individual conscience will remind the psychiatrist not to transgress. Ethical guidelines, however, could help the psychiatrist by providing a general outline of what is permissible, or forbidden.

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CHAPTER

6

Community Mental Health Care: Promises and Pitfalls

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INTRODUCTION

In every century, a proportion of every population has suffered from mental disorders, ranging from mild depression and anxiety to severe psychotic disorders. Of these, a relatively small group have been secluded in private homes, in prisons and in other institutions. Psychiatric hospitals were rare until the 19th century, even in the USA and Europe. After that time, increasing numbers of people in industrial nations were confined in psychiatric hospitals in a movement that resulted in a peak inpatient population in the mid 20th century. Even then, probably half of all people who had received a diagnosis of schizophrenia would have been living in ordinary households, although it must be said they received relatively limited professional care. In developing countries, the legacy of the colonial era has often been a large mental hospital in the capital city with an absence of any resource outside it [1].

It was only after the policy of incarceration was reversed that a true community psychiatry could be said to have developed in industrial countries. This required new types of relationships between health and social care, and the development of a range of new community social facilities for the treatment, care and support of people with mental problems. A variety of agencies and disciplines have become involved. The issue of scarce resources in less developed countries poses different problems and requires different solutions. This chapter focuses mainly on the issues affecting countries where there are sufficient resources for relatively complex decisions to be required about the best patterns of care.

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Over the last 50 years, there has been a progression of increasingly complex ideas about the nature of community psychiatry, starting from the simple relocation of old structures and hierarchies outside hospital, to the refinement by professionals of treatment arrangements in the community and, finally, to the conceptualisation of treatment provided within systems involving many agencies and people, including the recipients of care themselves.

This relatively recent historical process has been common to many areas of the world, albeit progressing at different rates [1–3]. Because our experience and knowledge relates to the UK context, we will draw on it for many of the sections in this chapter. In any case, it has more than parochial relevance precisely because the British National Health Service (NHS) has recently been very prescriptive of the sorts of services and treatments that should underpin community care, sometimes going appreciably beyond the evidential base. From this, service providers in other reasonably resourced polities worldwide may learn more of the promises and pitfalls facing community psychiatry.

We will thus rehearse the main themes that characterise the practices of community psychiatry at the beginning of this millennium and attempt to identify the innovations that are required to fulfil its promise. The central questions concern the way services are structured and integrated, the need, if any, for specialist services to deal with particular problems and patient populations, and the treatments that should be delivered. It is a large subject and the need for brevity has constrained us to be selective in our review.

THE ETHICAL AND SCIENTIFIC BACKGROUND OF COMMUNITY CARE

The ethical and scientific impulses behind community care are closely linked, and are both related to the ambiguous nature of care itself. Health care involves a tension between supporting functions and replacing them. Care that supports function encourages and assists people to engage in their normal activities, whereas taking over an ill person's functions leads to disengagement. In some cases the second option is the only practicable one. However, it is often the easier solution, and may therefore be adopted when it is not necessary.

Community care is invariably defined in contrast to what preceded it, that is, the incarceration of huge numbers of mentally ill people in large psychiatric institutions. Although the initial impulse towards the creation of these institutions in the 19th century was humane and therapeutic, this was lost as the numbers of people that were accommodated increased [4, 5]. In both the USA and the UK, the numbers peaked in the mid-1950s [6]. The peak

occurred somewhat later in other industrialised countries, and the asylum model had been widely exported, often under the process of colonisation, to many developing nations. Although some have attributed the decline in resident numbers to the introduction of neuroleptic medication, the change had probably already occurred in the USA and the UK, and was reflected in changing attitudes towards the business of mental health care and the locations in which it was carried out.

Aspects of the large mental hospitals came to be seen as counter-therapeutic, in particular the application of what was essentially a factory system for dispensing care, whereby economies of scale were adopted without considering their adverse consequences for patients. Because so many of the normal, everyday functions of patients were taken over by the institutions, most patients spent long stretches of time doing absolutely nothing. The ill effects of this were apparent, and led to the introduction of new techniques: occupational therapy from 1927 in Burgholzli in Switzerland, and industrial therapy somewhat later. These in turn increased awareness of the deleterious effects of institutions, and resulted in polemics against the asylum [7, 8]. It was argued that institutions were abnormal environments, that abnormal environments induced behavioural abnormalities in the people who lived in them, and that the most extreme behaviour would be seen in the most abnormal environments. Goffman's classic work was based on observational and interpretative sociological methods, essentially qualitative. However, around the same time there were developments in social psychiatric research that used quantitative techniques to establish the precise characteristics of social environments that mediated adverse effects for people with severe mental disorders, especially schizophrenia. The three major strands of research concerned the impact of environmental poverty on negative symptoms [9, 10], the role of stressful family environments in the re-emergence of positive symptoms [11–13], and the similar effects of stressful life events [14]. These studies were all carried out in the Medical Research Council (MRC) Social Psychiatry Unit in London, although they have been replicated and amplified elsewhere. Implicit in them is a therapeutic consequence: if the social environment has an impact on the behaviour and symptoms of people with severe mental disorder, changing the social environment for the better should improve their state. While this might not be easy, it clearly becomes an aspiration.

The most obvious way to change the environment of people living in institutions is to remove them, by arranging that they once more live in the community at large. There was always some difficulty with this, even for the people who were least damaged by their incarceration and who were consequently discharged first [15]. They were therefore prepared for the move by rehabilitative techniques carried out in hospital [9]. However, it was also felt that the mere fact of living in the community would improve

their quality of life (the idea that the community itself was therapeutic, by placing demands on individuals that they are obliged to meet: the demands of practical living, and the demands of social interaction [16]). By being obliged to cope with these things repeatedly, people discharged after a long stay in hospital would recover old skills and develop new ones.

These beliefs about the benefits of community living were the initial drivers of the reduction in long-term psychiatric hospital bed use seen in the USA and the UK in the two decades from 1955 to 1975. They presuppose that people with long-standing mental disorder have at least an adequate potential for acquiring new skills. Many of the problems that have afflicted the introduction of community psychiatric care arose because the capacity of discharged hospital patients to do this was overestimated.

While there was empirical evidence to support the potential benefits of moving people out of hospital, this would not have happened so quickly and extensively if it had not also been underpinned by the adoption of an ethical imperative. In the early days, this value system was formed around the relatively unspecified medical urge to make people better, but it came to be framed in terms of ''normalization'' and, more peculiarly, ''social role valorisation''[17, 18]. Being better was equated with being normal. Like many of the imperatives in community psychiatric care, it was an ideology with a potentially empirical justification, but one that pre-empted and sometimes resisted the necessary scientific work.

The initial movement towards discharging people from long-stay psychiatric hospitals came from within the profession of psychiatry, but it quickly attracted the attention of politicians and policy makers [6, 19, 20]. In Britain, the Minister of Health followed the wily and time-honoured procedure of turning a trend into a policy as early as 1962. In the USA, President John F. Kennedy launched an initiative for community mental health care in 1963. The most radical and explicit politicisation occurred in Italy in 1978: under Law 180, further admissions of people to mental hospitals actually became illegal, a move that had the result of bringing the Italian community psychiatry movement to the attention of colleagues all over the world.

In Britain, the discharge of long-stay patients into the community was sometimes carried out well, sometimes less so, but it has generally been seen as having positive effects overall on the discharged patients. Formal evaluation came rather late in the day, 20 years after the policy began, in particular through the Team for the Assessment of Psychiatric Services (TAPS) project [21]. This was an extremely detailed descriptive study of the closure of one particular large British mental hospital. Leff [22] concluded that the benefits of discharge clearly outweighed the disadvantages: mental state remained stable, while there were improvements in social behaviour and daily living skills. The patients' social life was enriched and they coped with and responded well to the increased freedom.

ORGANIZATION OF TEAMS FOR COMMUNITY MENTAL HEALTH CARE: POSSIBLE MODELS

If the move from large mental hospitals to the community is to be accomplished with the conservation of standards of care, most of the functions of the hospitals must be replicated by extramural services [6]. For people with long-standing and severe mental illness, continuity of contact and of care must be managed by teams of clinicians with far less reliance on segregated residence. It will not always be possible to avoid hospital admission, and thus there must be effective links between acute hospital units and the community workers. It is now generally accepted that continuous and effective care is best served by cohesive teams of workers. These community mental health teams probably function better if they involve collaboration between a range of different disciplines, allowing a pooling of skills. What is not clear is whether a generic team of this type can be used to cover all the needs of people with severe mental disorder living in the community. In some places, other teams have been developed to cater for people in acute crisis who as a result require intensive visiting and management for a relatively short period; for those who are reluctant to engage and in consequence have an increased risk of relapse or self-neglect; and for those whose mental disorders are compounded by substance abuse.

In many places, including the UK, generic multidisciplinary community-based mental health teams (CMHTs) are increasingly the basic building block for community mental health services. However, even in countries committed to this model, coverage is patchy and sometimes poor [3].

The idea that community teams should serve specified sectors was developed in order to make clear which patients the teams were responsible for, and which were the responsibility of neighbouring teams. This structure was first set up in France as long ago as the 1940s [23]. Sectorisation also forms the basis of funding allocation. In Britain, one relatively recent unresolved question is whether teams should operate on the basis of geographical or primary care list boundaries: this question is not so relevant in countries with less well developed primary care systems.

The introduction of CMHTs has had a number of consequences for the practice and management structure of psychiatry, mostly beneficial. CMHTs cannot work effectively without a relatively democratic management structure, as it is essential that the team members share their skills. The team leaders may or may not be senior psychiatrists. Tyrer [24] listed the features that together facilitate the effective working of CMHTs: skill sharing; coordination; flexible hours of working; development of good liaison; assertive but flexible outreach; rapid response to impending crises; access to an out-of-hours service; responsibility for hospital beds; and development of referral criteria.

The commonest option in the UK is for generic CMHTs to provide all the interventions required by adults aged 18–65 with severe mental illness in a local sector. Evidence from UK work by authors such as Tyrer *et al*. [25, 26] and Burns *et al*. [27] does suggest some benefits of the introduction of CMHTs working on the basis of structured, explicit and documented care programming. Tyrer *et al*. [28] reviewed randomized studies of management by CMHTs, compared with outcomes from standard care that did not involve such an integrated, community-based team. Team management appears to be better for patient satisfaction and acceptance of treatment, and resulted in fewer deaths by suicide. There was no clear advantage in terms of time spent in hospital, and overall clinical and social outcomes.

The central advantages of generic CMHTs providing a full range of services are likely to reside in continuity of care and in flexibility—clients may benefit from seeing the same staff both in the long term and in crisis. The generic CMHT is flexible in that, resources permitting, the intensity of input may be varied according to clients' current needs without requiring transfer to another team. A further advantage is that the service structure is relatively straightforward and readily understandable, and other local agencies in the sector will have only one team to deal with.

However, providing a full range of interventions to the population of a sector may make too many demands on staff skills—it may be difficult, while working in a generic team, to develop a high level of skill in crisis working or in engaging difficult clients. Moreover, staff who have chosen to work in CMHTs may not be keen to undertake the extended hours of work needed for the management of emergencies or for intensive attempts to engage difficult clients.

Even where there are well-equipped CMHTs, a number of patients have serious clinical and social needs that are not well met [29]. This leads us to the idea of specialist community teams to deal with difficult clients with long-standing severe mental illness and to provide a rapid response to crises. The Department of Health in England and Wales is the first in the world to adopt teams of this sort into its basic strategic plan [30].

ASSERTIVE COMMUNITY TREATMENT (ACT) AND INTENSIVE CASE MANAGEMENT (ICM)

ACT and ICM have been developed as ways of dealing with patients who slip through the net provided by services or are otherwise poorly served. ACT was developed in the Midwest of the USA in the 1970s. It was essentially a development of finding that long-term hospital patients could be successfully maintained in the community by well-staffed, multidisciplinary teams [31]. Stein and Test [32] extended this idea to include the man-

agement of the most acutely ill patients in the community. They were able to show in a randomized controlled trial (RCT) that ACT had considerable advantages over the ordinary procedures of hospital admissions. At 14-month follow-up, they demonstrated improvements in clinical outcomes as well as considerable reductions of hospital bed use. Costs were substantially reduced [33]. Moreover, the benefits were lost if ACT was withdrawn.

As Marshall and Creed [34] note, so-called ACT teams have actually been used in a number of ways: to facilitate the discharge of long-term inpatients, as an alternative to admission for acutely ill patients, and as a mechanism for keeping vulnerable patients with long-standing illness in the community. However, they argue that the style of management most likely to become widespread in routine care is ACT directed at keeping vulnerable people with severe mental disorders at home.

ACT has been shown to be an effective model in the USA [32, 35, 36] and in Australia [37]. However, the populations targeted in each randomised trial have varied [35], as have models of treatment [37]. Marshall and Lockwood [38] carried out a systematic review and found 14 RCTs in which ACT was aimed at the prolonged community maintenance of the most vulnerable people with severe mental illness. Overall, ACT was able to save one admission for every 10 patients treated. There was a 42% reduction in time spent in hospital. ACT was also effective in preventing people from disengaging from services. The authors were unable to confirm that ACT was really less expensive than standard care, and there was no good evidence of clinically significant improvement in psychiatric and social functioning, with the exception of improved residential stability. In their review, Mueser *et al*. [39] found that few studies reported any major improvement in symptoms. Earlier studies (such as Stein and Test's original study) may show more clearly positive results than more recent ones—this may reflect improvements in the care provided to those in the control ''standard treatment'' conditions.

In the UK, there has been an extremely enthusiastic governmental commitment to the introduction of ACT, now enshrined in the National Service Framework. In London, there are now nearly 20 services that could claim to have an assertive outreach function.

Although these may be seen as attempts to improve the quality of life of severely disadvantaged people, the worry is that the appeal of ACT to statutory authorities lies in its social control aspect: the cynic might see it as having a function similar to the electronic tagging of criminals, with the added benefit that if the tag is provided by identifiable staff members, they can be held responsible if adverse consequences follow from lost contact.

It would be nice if effective service models were generally exportable. However, implementation of similar models in the UK, for example, has met with limited success [40–43]. Possible reasons include: (a) a pragmatism

in British service innovations that meant the new services differed from what are now regarded as the defining criteria of ACT [44]; (b) the model may be inappropriate in the UK's service context and culture; (c) staff and service users may be uncomfortable with a model they think is relatively coercive and intrusive (some patients certainly complain that they are being harassed); (d) the services to which ACT is compared in the UK are more structured and community-based than those in the US trials; (e) some of the UK evidence has been based on pragmatic experiments rather than RCTs [e.g. 41].

In our view, the expectation that service models might be readily exportable may not be right. The paradigm that treats ACT like a drug that can be expected to have standard effects under any social conditions, if administered properly, seems implausibly asocial. It ignores social contexts: the living situations of people with severe mental illness, the problems they face, the attitudes towards mental illness in the wider community, and so on. These may well be major factors influencing what is effective. Moreover, culture influences treatment acceptability—privacy and freedom from official intrusion tend to be highly valued in some cultures, and ACT involves a breach of patients' right to say no to interventions even when they would be regarded as capable of valid consent.

In Britain, CMHTs have been developed since the programme of closure of large mental hospitals resulted in the discharge of people with long-standing mental disorders. They were intended to provide care for these patients and also for similar, later cohorts who had never been long-term hospital residents. However, the staff often chose to target a whole range of mental disorders. The teams were thereby unable adequately to meet the needs of their clients with severe disorders. This move away from treating severe mental illness was also seen in the US Community Mental Health Centers of the 1960s and 1970s [45]. The number of beds available in acute hospital units was also reduced, and admission rates consequently rose. Admissions were often on an involuntary basis and mainly concerned people with severe mental illness. For this reason, CMHTs have been reoriented towards this, their original client group.

Marshall and Creed [34] argue that, where innovative services have been introduced in Britain to deal with the problem of patients with unstable community tenure, they were not ACT teams, but ICM teams, essentially CMHTs whose members carry small case-loads. They contend that because of the failure to distinguish between ACT and ICM, the argument was made to introduce the latter on the basis of what were actually trials of ACT [46]. Marshall and Creed [34] argue that ACT is a highly specific, team-based approach, specified sufficiently to permit the assessment of fidelity. Somewhat late in the day, the key features of ACT have now been listed in fidelity scales [44, 47]. These include assertive outreach, case-sharing, small case-

loads, a team leader who is also an active team member, dedicated psychiatric time, 24-hour cover, and an essentially community location. Marshall [48] claims that the definition of ICM is much vaguer and more flexible. However, there is some room for scepticism about the clear distinction that Marshall and Lockwood [49] made between ACT and ICM—this is based not so much on clear examination of the content of programmes as on nomenclature. Probably the clearest difference that can be identified between the two models is the team responsibility taken for clients in ACT programmes, as opposed to management by individual case managers in ICM.

There is considerable dispute about whether the five RCTs carried out in the UK in the 1990s tested ICM or ACT. The results of these trials [25, 50–53] were disappointing. Like ACT, they did not deliver consistent improvements in clinical or social outcome, but did improve the numbers of patients remaining in contact with services. If anything, costs were increased. So, for example, the UK700 trial included 708 patients with psychotic disorders and a history of frequent hospital admission in four centres [54]. They were randomised to ICM or standard care. The trial showed no difference in hospital bed use, mental state, social functioning, quality of life, or patient satisfaction. However, contact with case managers was better maintained in the intensive condition.

The debate about the findings of these five trials has wider relevance, as it concerns the issue mentioned above of the exportability of specific techniques of service organisation. Thus, arrangements that worked in the USA and Australia may not work in the UK, and may not work in other countries either, depending on the service context. Some British authorities [e.g., 55] argue that ICM is so similar to ACT that the ICM trials are sufficient to suggest that ACT itself would not work in the UK either. In their excellent and comprehensive review of the evidence on different models of community care provision and case management, Mueser *et al*. [39] likewise do not see ACT and ICM as very clearly distinct models: they group the two together in their summary of the evidence.

Marshall and Creed [34] take a very different position. They contend that ICM failed in the UK because it was not sufficiently similar to ACT. These authors then point out that there has been no RCT of ACT in the UK that has used fidelity scales to establish that the model is in fact being followed. However, we are wary of the view that unless every element in a package is present, that package will not work, particularly in view of the fact that elements of ACT have evolved over the years. The result is to protect the hypothesis of effectiveness from refutation: under this argument, if effectiveness is not demonstrated, it is because the package was improperly applied, not because it might not work in specific circumstances. Ideally, interventions should have some robustness: they are more impressive if

they still work despite variations in application. This seems to be the case, for example, with family interventions (see below). The fidelity scales used in ACT seem to have been developed in response to failed attempts at replication.

At one level this argument is trivial. If there is sufficient consensus that ACT has a fixed content, then ACT has not been properly tried in the UK. The service structures that have been tried have not worked very well. Thus, it would certainly be useful if there were an RCT of ACT in the UK, and people should probably be more precise in their description of content of the interventions that are being evaluated.

Overall, there is evidence that assertive outreach teams reduce time in hospital and costs, that they are effective in engaging many clients, and that client and carer satisfaction are relatively good. Staff can be selected for their skills with difficult-to-engage clients and have the opportunity to develop these further in a context where case-loads are low and there is time to think. Assertive outreach teams are disappointing in relation to some desired outcomes—for example, there is little evidence that they benefit social functioning.

Limitations to current knowledge and unanswered questions which emerge include the following:

1. The precise nature of interventions delivered is often quite unclear, so that it is difficult to identify ''active ingredients''. The nature of control interventions is even less specified, again leading to considerable uncertainty about factors critical to better results. The standard care with which these models have been compared is generally office-based rather than involving contacts in clients' homes.
2. Considering the lack of impact on social and vocational functioning of ACT and ICM and also the fact that their benefits are not sustained long-term, the incorporation of specialized interventions within these models may be a valuable next step, as in interventions for social skills, getting clients back to work, and dual diagnosis.
3. ACT may also create relatively high levels of dependence on mental health services rather than encourage the building of other social networks, and this might account for the lack of improvement in social and vocational functioning. Given this and the impermanence of the other benefits of ACT and ICM, the incorporation of specialized interventions within these models may be a valuable next step.

Assuming that some clients do benefit from ACT, we do not yet know how many, how to identify them, or whether it is a useful model in every geographical context. It is still uncertain whether ACT is a solution for the most difficult client groups of all—those who lack insight into their ill-

nesses, are deeply hostile to statutory services, repeatedly refuse to let mental health workers into their homes, and have histories of serious violence. The consequences of ACT for the system of local services as a whole also need to be considered—where resources are constrained, ACT may tie up a considerable proportion in the care of a relatively small sub-group of clients. This may result in a loss of flexibility in treating other clients—particularly the group who may benefit intermittently from a more intensive input, but for whom it is not a consistent long-term requirement. There is also scope for boundary disputes, difficulties over allocation between teams, and resentment from other staff of the "special" working conditions of ACT teams. Local service structures may consequently become very complex.

The debate about ACT is peculiar to English-speaking countries, and mainland European psychiatrists may be more concerned with the development of generic community services. However, it does emphasise that services need to be designed in the light of the local social, cultural and ethical environment.

It has commonly been assumed that generic CMHTs cannot carry out very intensive work with their clients, make persistent attempts to engage difficult clients with services, or respond rapidly to crises. However, this may be because they are currently under-resourced. With more resources it might be possible to undertake intensive home treatment and assertive outreach within CMHTs, with benefits in terms of continuity of care, flexibility and variety of work. However, this does assume very flexible, capable and motivated CMHT staff.

THE CRISIS RESOLUTION FUNCTION

After several decades of reduction in the numbers of psychiatric beds, there is now substantial agreement that the great majority of long-stay psychiatric inpatient beds can be replaced with community resources such as supported hostels and CMHTs providing support and treatment at home. Given adequate resources, this can be done without detriment to clients.

However, controversy remains about the extent to which community alternatives can substitute for *acute* inpatient treatment. The Monitoring Inner London Mental Illness Services (MiLMIS) Project Group [56] has suggested that, at least in inner London, this process has been pursued well beyond the point supported by current evidence, arguing that service planners have failed to distinguish clearly between the functions served by acute and by long-term beds. The result has been a misplaced assumption that acute beds may be closed as easily as long-stay ones, and that generic CMHTs can provide adequate substitute care. Moreover, Tyrer [57] has argued that reducing local acute beds beyond a certain minimum number

results in an inefficient and profligate service, with heavy use made of acute beds outside the catchment area, a resulting breakdown in continuity of care, and a further rise in admission rates. Thus, in hard-pressed areas, such as inner London, the process of reducing acute beds and substituting community-based alternatives may now have been taken as far as is feasible, and perhaps further.

However, there is a counter-argument. Few CMHTs have the capacity to visit acutely ill patients at home on a daily basis [58]. It seems inherently unlikely that community-based care of this low intensity is an adequate substitute for the acute ward for many patients. However, more focused and intensive community-based service could effectively take on this emergency function, at least for some acutely ill people. Certainly, there are good reasons for seeking alternatives to the acute ward. In addition to being an expensive form of service, inpatient care suffers from widespread unpopularity with service users [59], and inner city psychiatric wards are characterised by very high levels of compulsory detention and of violent incidents [e.g., 56].

Apart from a few small-scale descriptions of crisis houses, most of the research on substitutes for inpatient care has focused on home treatment programmes. In these, specialist teams, generally available for 24 hours, or at least over extended hours, assess and manage acutely ill patients in their homes. Visits may even be made more than once a day, and team professionals are accessible by telephone to patients and their carers. Pioneering examples of this service model were established and evaluated by Stein and Test [32] in Madison, Wisconsin, USA, and by Hoult *et al*. [37] in Australia (it is interesting that these services have been used as models for both ACT and crisis intervention). The results were promising, with evidence of effective substitution of community for hospital-based care for at least some patients, an overall reduction in bed use, and improved satisfaction among patients and their carers.

In the UK, Merson *et al*. [40, 60] have recently described a team which aimed to assess and treat patients as far as possible outside hospital, and appeared to achieve lower levels of bed use, lower costs and greater patient satisfaction than the conventional, largely hospital-based service with which the team was compared. Muijen *et al*. [61], again in London, carried out a randomized controlled evaluation of a home treatment service based on Stein and Test's model. This also showed evidence of benefit, at least in the early stages of the team's functioning, again with a reduction in bed use and greater patient satisfaction.

Some of these teams have in fact followed hybrid models, combining initial intensive home treatment with subsequent retention of patients on the team's case-loads and use of an ACT approach. While reductions in bed use have often been substantial, most authors agree that an entirely bedless

acute psychiatric service is unlikely to be attained: acute hospital admission at least for a brief period continues to be seen as necessary for some of the most acutely disturbed and socially dislocated individuals.

Despite these indications of effective substitution for acute inpatient care, significant weaknesses remain in the evidence on crisis teams. Kluiter [62] has highlighted several important unanswered questions. These include the small number of studies carried out, the small numbers of subjects within these studies, and the relatively brief periods of follow-up. It is often unclear which patients have been excluded at the outset from home treatment and what the outcome has been for the substantial numbers of study non-responders.

In interpreting the efficacy of crisis teams, we again need to assess how far the services received by the control group resemble current routine practice. In the RCTs so far carried out, the control groups have mainly been served by hospital-based services. However, in many Western countries the preferred model of treatment is now community-based multidisciplinary mental health teams. These may have advantages over crisis teams in managing emergencies: even though they are not specialists, team members will already know many of the patients presenting in emergencies. This will make it easier for them to assess patients' needs, and to judge whether hospital admission is necessary and whether compulsory detention is justified. They may also be better at maintaining engagement and adherence to treatment through a crisis because of their established relationships with patients. A modern CMHT may well be better at managing emergencies than the control services in the experimental studies discussed: we thus still lack evidence of the relative advantage of crisis services in this more modern service context.

A further point: it is easy to reduce admissions in areas where clinicians have previously been relatively ready to admit, and patients relatively willing to go to hospital. However, the situation may be very different in areas where clinicians avoid admission because the demand for beds greatly outstrips supply, where the majority of admissions are compulsory, and where a highly aroused, sometimes threatening atmosphere on the wards makes patients reluctant to stay in hospital. Moreover, crisis teams may not be an effective substitute for admission in areas of low social cohesion and high deprivation. Failure to replicate may occur because home treatment is less feasible in areas where many patients live alone and have no informal carers, and where homelessness and poor living situations are frequent.

Overall, the gains from introducing crisis teams have appeared rather limited. Reduction in costs and in inpatient bed use and some increase in patient satisfaction have several times been reported. However, there has been little evidence of significantly better outcomes on dimensions such as

symptoms, social functioning, social networks or quality of life. Ideally, we should be developing forms of acute care that actually do produce better outcomes than conventional inpatient care.

Kluiter [62] summarised the current state of evidence, stating that there is ''not nearly enough information to base general policy on''. In particular, he noted, ''Community care alternatives are capable of reducing the need for inpatient treatment. The trouble is that we do not know to what degree. Current scientific knowledge is not sufficient to base a radical reduction in beds on.''

This question of how far the transfer of acute care into the community may be taken is pressing wherever there is a shortfall in acute inpatient bed provision in relation to demand. Should this be met by a pragmatic retreat, with an increase in inpatient bed provision, or should we be developing more effective means of managing crises in the community, following the emphatic wishes of service users? Convincing evidence from high quality research is urgently needed for rational decision-making.

Intensive home treatment generally appears to be preferred by clients and relatives alike. They place a high priority on rapid access to emergency assessment and intervention at home, and on 24-hour intervention. Easily accessible crisis teams are also likely to find favour with primary care physicians. The existence of crisis teams, particularly out of hours, reduces the burden of working in generic CMHTs, in that key workers no longer have to manage acutely ill patients in the community single-handed, and have someone to pass responsibility on to when they go home at 5.00 p.m.

The possible combinations of generic and specific mental health teams are listed in Table 6.1. In our view the jury remains out on the choice of service

Table 6.1 Possible combinations of generic and specific mental health teams

1. All treatments delivered by a generic community mental health team (CMHT) serving a given area
2. One CMHT and one crisis intervention team per area
   a) Crisis intervention/home treatment team covers catchment areas of more than one CMHT
   b) CMHTs provide cover during the day, a crisis team provides out-of-hours cover to a wider area
3. Generic CMHT plus assertive outreach team
   a) Each sector has both CMHT and an assertive outreach team
   b) Each sector has CMHT; assertive outreach team covers several sectors
4. CMHT plus assertive outreach plus crisis team
5. Generic CMHTs with specialist crisis and/or assertive outreach functions within them
6. Specialist intervention functions developed by distinct teams (e.g., dual diagnosis, rehabilitation, vocational rehabilitation, family interventions, etc.)
7. Specialist functions developed within teams

structure best suited to the management of people with long-standing and severe mental illness.

THE CONSEQUENCES OF THE MOVE TO COMMUNITY MENTAL HEALTH SERVICES FOR INFORMAL CARERS

Living with someone who has schizophrenia is likely to be stressful and upsetting [63]. The term ''burden'' has been used to describe the difficulties of living with someone who is mentally ill, although this has a slightly pejorative ring. Hoenig and Hamilton [64, 65] made the important distinction between objective and subjective burden. The objective component relates closely to the level of social performance that patients can manage. However, it is probably the subjective component that is more important for the well-being both of informal carers and of patients. At given levels of objective burden, individual levels of distress show considerable variation [66]. The effects of burden on the social relationships of informal carers have been consistently documented [63]. Likewise, their difficulties are compounded by financial strain consequent on the duties of caring. The effect of burden on carers' own mental health is not inconsiderable. Indeed, Davis and Schultz [67] have established that grief symptoms are common long after the event in people whose children have developed schizophrenia.

It might be expected that objective burden would be increased by policies of care which reduce the time the sufferers spend in hospital. This was shown in the UK as early as the 1960s [68, 69]. New community-based service increased both the number of people caring for relatives and the degree of burden. Care may be equally burdensome in developing countries. Thus in Malaysia an appreciable proportion of caring relatives developed stress-related mental disorders themselves [70]. The experience of burden is also considerable in the relatives of patients with bipolar affective disorder [71, 72]. Although burden is persistent, it may be reduced by improvements in coping strategies and increases in practical support. Likewise, improvement in the patient's social functioning does lead to a reduction in perceived burden [73].

High expressed emotion (EE) relatives seem to be particularly overwhelmed by the difficulties of living with someone with schizophrenia. It is the level of perceived burden that is most characteristic of these relatives [74–76]. In one study, perceived family burden was found to be more predictive of relapse than EE [77]. Scazufca and Kuipers [78–80] concluded that EE was itself a measure of the relative's *appraisal* of difficulties.

Therefore, the policy of locating care in the community does have consequences for relatives and other informal carers. By and large, they are not and have not been consulted in the formulation of this policy. There is thus

an obligation on those responsible for the policy and on those delivering professional care to people with mental disorders to provide at the very least a degree of support to relatives. This may involve formal interventions of the sort described below. However, in many cases it requires only an evaluation of their needs, the provision of some practical and emotional support, and the sense that their involvement in their relative's care is valued by clinical staff.

REHABILITATION WITHIN THE COMMUNITY

The realignment of psychiatric services into the community in the last half of the 20th century has had effects on the way rehabilitation is provided, not all of which have been fully thought through. Wykes and Holloway [81] have reviewed the position of rehabilitation among community services. It is probably fair to say that the introduction of community care had an adverse overall effect on the provision of formal procedures of rehabilitation (particularly vocational rehabilitation), and we are only now beginning to restore the situation. Vocational rehabilitation is of central importance in remedying the social exclusion experienced by many people with severe mental disorders, of whom between 60% and 85% are unemployed [82]. In individual cases, this situation can be assisted both by prevocational training and by supported employment. The latter involves placing clients in ordinary competitive jobs while providing them with support from trained ''job coaches'', and has been shown in a recent systematic review to be more effective than prevocational training in maintaining people in open employment [82].

A major aspect of the practice of rehabilitation over the last 40 years has been the attempt to refine its procedures by psychological assessments and techniques. This is self-evidently a good thing to attempt, but in many respects it has been disappointing. The psychological techniques have largely foundered because in focusing on specific deficits they have taken patients away from the real-life situations within which deficits in their psychological functioning led to adverse social effects. The demonstrable benefits of the techniques could not be generalised back to situations where performance enhancement would have a real impact on social functioning and quality of life [83, 84].

Nevertheless, some of the relevant techniques have continued to engage the energies of researchers and practitioners alike. New meta-analytic evidence raises serious doubts that two of these techniques are actually effective [85].

Social skills training is commonly used in the USA [86] and was strongly advocated in the recent American Psychiatric Association's guideline on the management of schizophrenia [87]. It is less popular in Europe and hardly

used at all in the UK, mainly because of concerns about generalisability. The aim of social skills training is to increase social performance and reduce social distress and difficulties of the sort experienced by people with schizophrenia. Many people with schizophrenia experience debilitating problems affecting their ability to interact socially, and these exacerbate their social isolation and stigmatization. This in turn leads to a poor prognosis and quality of life [88]. Social skills training programmes rely on a range of structured psychosocial interventions, which may be carried out either individually or in groups. By enhancing social performance and reducing difficulties in social situations, social skills training may reduce overall symptomatology and, perhaps, relapse rates. The interventions are essentially behavioural and emphasise careful assessment of social and interpersonal skills. Importance is placed on both verbal and non-verbal communication. This includes the ability to perceive and process relevant social skills and to provide social reinforcement to others. Individual behavioural elements are built up into complex behaviours. The techniques include the establishment of a therapeutic alliance; goal setting; behavioural rehearsal; positive reinforcement; shaping, prompting, modelling, and interim practice and homework [86]. The homework tasks are intended to assist generalization. The techniques have been extended to provide assistance with a wide range of interpersonal skills, medication management and coping skills.

Although there is a considerable literature relating to the evaluation of social skills training as an effective treatment, there are relatively few RCTs. Pilling *et al*. [85] identified nine RCTs that met their criteria for inclusions. All view social skills training as an adjunct to standard care. Although there was considerable variation between studies in relation both to the training programmes and to the symptoms targeted, all involved the therapeutic elements described above. Pilling *et al*. [85] found no significant reduction in relapse rates, whatever the period of follow-up. Although there was no significant difference between social skills training and the active comparison treatment in terms of dropout rates, there did tend to be more dropouts in the social skills condition.

However, the real purpose of social skills training is to improve social functioning. Unfortunately, there have been great variations in the measures used in the different studies. Hayes *et al*. [89] compared social skills training with a treatment involving a discussion group focusing on interpersonal issues. There was no significant difference in the two tasks designed to assess effective social interaction. Marder *et al*. [90] found significant improvement in social adjustment when social skills training was compared with a supportive psychotherapy group. Liberman *et al*. [91] found no differences in scores on the ''Profile Adaptation of Life'', but did find significant, albeit small, improvements in quality of life.

All in all, Pilling *et al*. [85] felt there was no clear evidence of the benefits of social skills training from the trials they reviewed. There is some positive evidence from a number of controlled non-randomized trials. However, overall, one must conclude that the results of rigorous scientific investigation of social skills training are disappointing.

Cognitive remediation is another treatment which is aimed at deficits in functioning in schizophrenia. It has recently become the focus of much attention. The interference experienced by many people with schizophrenia in day-to-day functioning has been related to a number of cognitive deficits like problems with attention [92], memory and information processing [93], and executive functions like goal-directed planning [94]. These deficits have been subjected to considerable scientific and clinical investigation [95]. It is a natural extension of this work to attempt to ameliorate these deficits. Cognitive remediation is aimed at deficits in attention, speed of processing, memory function, abstract thinking and planning [96, 97].

While cognitive remediation takes a number of forms, it usually concentrates on repetitive laboratory-based techniques. Patients practise on laboratory-based tests of cognitive function, or procedures specifically designed to address the cognitive deficit. While some of the early studies suggested that the techniques were successful in improving performance on specific cognitive tests, others have been troubled by the problems of generalization to daily living tasks that depend on the cognitive processes involved [96].

Brenner *et al*. [98] combined specific cognitive remediation strategies with other psychosocial interventions. Basic training in cognitive skills was integrated with training in social skills, or personal problem solving. This leads to the problem of inferring which of the elements of this diverse package resulted in beneficial effects.

Pilling *et al*. [85] were able to identify four RCTs of cognitive remediation, although there was considerable variation in the training received by participants [97, 99–101]. There was a corresponding variation in the outcome measures employed. In order to make comparisons between studies, Pilling *et al*. [85] concentrated on five areas: mental state, attention, executive planning and decision-making, visual memory, and verbal memory, but concluded from their systematic review that there was very little evidence of the expected effects.

The techniques of cognitive remediation, as carried out so far, require computer technology. As such, they are likely to be restricted to well-funded services in Western economies. However, the results to date are disappointing, despite the obvious face validity of the approach. Certainly at the moment, there seems to be no good reason for including cognitive remediation in the techniques that might be regarded as important components of community psychiatry.

THE PROVISION OF SPECIFIC TREATMENTS BY CMHTs

Health services are essentially mechanisms for delivering treatments in their broadest sense. Such mechanisms are obviously necessary, but not sufficient, conditions for effective care. Research on service organization in the last 10 years suggests that, at least for the main forms of care so far evaluated, changing the structure of community services has relatively little impact on clients' overall clinical and social outcomes, and the gains that do occur are generally not sustained after the intervention is finished. Little attention has been devoted to the sorts of treatments that are most effective in community-based care. What sorts of treatments ought to be deliverable by good CMHTs? They may be divided into social, psychological and pharmacological, although services rely very heavily on the last of these in large parts of the developed and developing world. For a range of reasons, evidence of effectiveness is most strongly based on the pharmacological components of treatment. However, pharmacological treatment must be embedded in a beneficial social context for it to gain the acceptance of those it is intended to benefit.

Nevertheless, recent literature suggests that specific treatment interventions appear to have a somewhat greater benefit on client outcomes than do variations in service organization. These treatments include family treatments and cognitive behavioural therapy (CBT). Benefits have also been shown for some dual diagnosis interventions and for vocational rehabilitation. Therefore, a crucial question is how to plan services to allow delivery of these specific treatments to those who will benefit. In the USA, interventions such as dual diagnosis treatment and vocational rehabilitation are provided by separate teams which specialize in these areas, but which take on the overall care of the client.

Community mental health care relies crucially on the provision of adequate training for the staff members involved. This training is as necessary for specific aspects of treatment as it is for managing the organization of services. Nevertheless, there is a clear training deficit, which is most apparent in the treatment component. We believe the newer treatments promise much, but if training is not provided, the hoped-for flowering of community services in this new millennium will be frosted. They will lack the content essential for their optimal functioning and fall back into a mere monitoring and crisis response role.

The acknowledgement that the family atmosphere plays a role in relapse in schizophrenia led to a number of evaluations of family interventions [e.g., 102–107]. Overall, these interventions have been successful, indicating that it is possible to modify family atmosphere and thus to reduce relapse rates. However, this is probably dependent upon the timing of intervention, the techniques used, and the expertise of the therapists using them. Thus, the

Amsterdam study of family treatment in schizophrenia [108] was generally unsuccessful, although it is not clear exactly why. There was an overall low rate of relapse, but this was actually slightly greater in low EE families in receipt of family treatment, raising the possibility that the intervention paradoxically increased stress levels in these families. Hogarty *et al*. [106] have suggested that the changes leading to a reduction in EE may be a sufficient but not a necessary component of intervention.

A useful meta-analysis of these treatments has recently been carried out by the British National Schizophrenia Guideline Group [109, 110]. In the process, a number of related issues were clarified. The authors identified 19 RCTs comparing family therapy with some other treatment. They were conducted in a wide range of cultural and service contexts. The early studies of intervention showed excellent outcomes, and, overall, the literature confirms these good results. However, in their review, Mari and Streiner [111] suggested that intervention in the more recent studies appears to be less effective. They attributed the apparent decline in effectiveness to the enthusiasm and charisma of the people conducting the earlier studies. However, the diminishing effect of family intervention with time may also be explained by the fact that the later studies involved *group* treatments of the families, whereas the earlier studies consistently relied on the treatment of individual families. Thus, for single family therapy the ''number needed to treat'' (NNT) to prevent relapse in the first year of treatment or to prevent readmission was around six. In the second year of treatment, the equivalent values were even lower, at less than four. The NNT to prevent a relapse in the *follow-up period* after the end of treatment was seven for individual family treatment, although this rose to 21 for readmission. In contrast, Pilling *et al*. [110] found that group-based family treatment is marginally (but non-significantly) *worse* than the comparison treatment.

It does seem unlikely that group treatments are entirely ineffective, given that social comparison can be a powerfully reassuring group process. However, when the chosen outcome variable is the re-emergence of psychotic symptoms, or readmission to hospital, it is clear that single family interventions are much more effective, and must be considered the first choice. There was little evidence to support the contention that the effects of family therapy might be mediated through improved compliance with medication.

Another new initiative in the psychological treatment of schizophrenia is CBT, largely developed over the last 10 years. Its obvious advantage over family therapy is that it can be offered to patients who are not in contact with relatives. CBT involves patients establishing links between their thoughts, feelings or actions with respect to the positive symptoms that they experience. The treatment attempts to correct the misperceptions, irrational beliefs or reasoning biases that contribute to their symptoms. It

also involves clients monitoring their own thoughts, feelings or behaviours in relation to their experience of positive symptoms and the promotion of alternative ways of coping with their symptoms.

Pilling *et al.* [110] identified nine RCTs of treatments that met these criteria. In all cases, the cognitive behavioural intervention was an adjunct to standard care, which invariably included treatment by antipsychotic medication. The RCTs varied in whether they compared CBT with standard care or with another active treatment. Pilling *et al.* [110] examined a number of outcomes in their meta-analysis. There was some evidence that CBT was capable of reducing relapse and readmission rates when compared with all other treatments, although this fell just short of significance. However, the primary target of CBT is overall improvement in mental state. There was a clear indication that, both during treatment and over the follow-up period, CBT was responsible for a clinically significant improvement in mental state. Moreover, the improvements tended to increase after the end of treatment. Overall, there was no evidence that CBT was associated with a high dropout rate compared with other treatments; rather the reverse.

CBT is at an early stage of development, but the results of the RCTs reported so far are encouraging. The treatment is potentially applicable to a wide range of patients with schizophrenia. It requires considerable expertise, but nothing beyond the capacity of most clinical psychologists, and enthusiastic members of other disciplines would probably be able to acquire the skills as well.

THE IMPLICATIONS OF DUAL DIAGNOSIS FOR COMMUNITY MENTAL HEALTH SERVICES

An increasing number of people are given a dual diagnosis of severe mental illness and substance misuse. The prevalence of substance abuse in most US community samples of individuals with psychotic illnesses falls between 30% and 50% [112]. The frequency of dual diagnosis in other countries is likely to vary, mainly in response to different cultural attitudes to substances of potential abuse. Dual diagnosis is associated with greater inpatient service use, poorer adherence to treatment, more frequent violent behaviour and probably more severe clinical and social problems than psychotic illness alone [113, 114].

Seeking effective ways of developing services for this group of patients has been one of the major tasks undertaken by service planners and health service researchers in the USA in the last 15 years [115]. A range of service models has been developed. Research on dual diagnosis is recent and relatively rare on the eastern side of the Atlantic, and there are as yet very few specific services addressing this combination of problems.

The options for management of individuals with dual diagnosis within conventional mental health service configurations are as follows: (a) treatment provided exclusively by generic CMHTs; (b) treatment provided exclusively by addiction services; (c) joint management by generic adult and addiction services, either concurrently or sequentially.

However, various impediments to effective care may arise with each of these strategies [116, 117]. Thus, workers in the CMHTs may lack training, experience and confidence in helping people with addictions. Staff responses may be punitive rather than therapeutic, with the substance abuse conceptualized as difficult behaviour rather than as a disabling problem for which treatment is needed. Finding residential places for individuals with dual diagnosis is particularly difficult.

On the other hand, staff in addiction services may sometimes lack confidence in working with individuals with psychotic illnesses, especially where they have active symptoms such as delusions and hallucinations. Conventional addiction treatments may be inappropriate for individuals with severe mental illnesses, especially where the approach is relatively confrontational, where there are strict limits on tolerance of relapse, and those who do not achieve abstinence are ejected from the service, or where the emotional temperature in treatment sessions tends to run high. Some non-statutory addiction services may not permit clients to be on any form of medication, making them inappropriate for many with psychotic illnesses.

However, joint management by addiction services and generic mental health services has its own problems. Many individuals with dual diagnosis lead relatively chaotic lives, are ambivalent about engaging with services, and tend not to adhere to treatment. Thus continuity of care and engagement are already difficult to maintain for this group, and the difficulties may be worse if two distinct services are involved and clients are expected to keep two distinct sets of appointments.

The literature on dual diagnosis services in the USA indicates a number of central principles common to many services. In order to minimize barriers to obtaining treatments and maximize continuity of care, treatment for severe mental illness and that for addictions are closely integrated, with both delivered by the same team. Training and supervision are provided so that individual workers have some skill and confidence in the management both of psychotic illnesses and of addictions. Community dual diagnosis services often adopt the main principles of assertive outreach teams, with small case-loads, a team approach, and intensive attention to engaging clients. In the initial phase of treatment, there may in fact be very little active work on the substance abuse, with efforts directed primarily towards establishing a relationship with clients and persuading them to accept contact with services.

Addiction techniques, such as motivational interviewing education about the effects of substance abuse and relapse prevention, are used. Attention is directed towards the social skills required to maintain abstinence. For example, if clients are not assertive enough to refuse drugs offered by their peers, staff may focus on developing the skills required for them to do so. Staff aim to identify and address the reasons for substance misuse. These may include self-medication of distressing symptoms, escape from boredom and social isolation, or difficulties in coping with stressful social situations or relationships. Addiction treatments are modified so that the problem is confronted in a gentle manner, and clients who have difficulty in attaining abstinence or who relapse very frequently are not ejected from the services. Staff help clients to find activities and social networks that do not involve substance misuse, and ensure that basic needs for housing, food and money are met.

Well-known examples of specialist dual diagnosis services in the USA include the "continuous treatment teams" which have been established throughout New Hampshire by Drake *et al*. [116–118]. These teams have a case-load consisting exclusively of individuals with dual diagnosis, for whom they have 24-hour responsibility. Case-loads are small, at around 12 clients per case manager. A combination of group and individual interventions is used. For many clients, the initial phase of treatment is a "persuasion" phase, in which the aim is gradually to raise their awareness of the problems caused by their substance misuse. Once some motivation for work on substance abuse is established, an "active treatment" phase follows, in which more intensive and explicit substance abuse interventions are employed.

Descriptions of a variety of models for specialist dual diagnosis treatment have been published, including the outpatient group therapy programme described by Kofoed *et al*. [119] and the intensive dual diagnosis treatment programme based on an inpatient ward described by Franco *et al*. [120]. These accounts provide some evidence of success in engaging clients in treatment and may have improved their short-term outcome. However, as yet, relatively few researchers have published more methodologically robust studies with appropriate comparison groups, longer follow-up periods and substantial numbers of subjects.

Jerrell and Ridgeley [121] followed up 146 subjects over two years, comparing three different approaches to dual diagnosis, one based on behavioural skills training, one on intensive case management and one on an Alcoholics Anonymous (AA) model. Over the two-year study period, the sample as a whole showed improvements in drug and alcohol-related symptoms, reductions in service use and costs, and a trend towards better social adjustment. Outcomes were better in the groups receiving behavioural skills training and intensive case management than for the AA-based

programme. In Washington, an integrated programme combining mental health, substance abuse and housing interventions was compared with standard management for homeless individuals with dual diagnosis [122]. There was some evidence of benefit from the integrated programme, with fewer days in institutions, more stable housing and greater improvement in alcohol problems. Differences between the programmes in degree of recovery from drug problems and in changes in psychiatric symptoms, social functioning and quality of life were unremarkable.

A large randomized controlled trial of ''continuous treatment teams'' has been carried out in New Hampshire. The results have not yet been published in full, but preliminary reports are promising, with reductions in hospitalization, improvements in functioning, and almost half the teams' clients achieving a degree of abstinence after three years [117].

Some specialist North American dual diagnosis services do seem largely to have failed. For example, in the community-based programme described by Lehman *et al*. [123], very few people with dual diagnoses cooperated with an attempt to initiate intensive treatment for them on a day-patient basis. The likeliest reason for this was the absence of an initial phase during which the main focus was on engaging clients and increasing their motivation. Similarly, Bartels and Drake [124] found no evidence of benefit from an intensive residential programme for dual diagnosis, and concluded that successful treatment needs long-term work within the clients' usual social environment and with great attention to engagement.

Thus in North America some interesting and promising models for management of individuals with dual diagnosis have been developed, although the evidence base for them is as yet not wholly satisfactory. Are we at a stage where it would be beneficial to transplant such American models to other countries? Particular local factors have a bearing on this. First, the separation between mental health and addiction treatment systems may not always be as radical as in the USA, where training and funding are generally wholly distinct for the two specialties. Thus, for example, in the UK many workers have some basic training in both areas, so there will be a stronger basis for developing good practice for dual diagnosis clients within existing service structures. Secondly, in many Western countries, services are principally sector-based, and CMHTs, where they exist, are usually generic, providing a full range of services to the severely mentally ill population of a small geographical catchment area. Specialist dual diagnosis teams serving larger catchment areas might struggle to achieve close integration with other services in their catchment areas, such as primary care and social services. Moreover, specialist services with no obligation to accept everyone from a particular catchment area might develop barriers to taking on the most complex and difficult-to-engage clients. The success of the US specialist teams in engaging clients in treatment may also be related to the avail-

ability of coercive methods. Discharges from hospital may be conditional on acceptance of treatment, and representative payeeships allow mental health professionals to take close control of the finances of clients known to be spending state benefits on drugs and alcohol [125]. Such methods might not necessarily find acceptance elsewhere, and could, for example, fall foul of the European Convention on Human Rights.

In our current state of knowledge, it might be worth listing the possible options for increasing expertise in the management of dual diagnosis patients: (a) developing closer links between generic mental health and addictions services; (b) providing training and supervision in addictions techniques for all community mental health staff; (c) attaching specialist dual diagnosis key workers to community mental health teams; (d) developing specialist dual diagnosis teams; (e) developing a specific dual diagnosis programme within an assertive outreach team.

Sub-groups among those with dual diagnoses may be best served by different models, so that a combination of the above strategies may be appropriate. Thus, there may be a group who are relatively compliant with services and whose needs might be met by improving links between addiction services and CMHTs, and offering appointments with workers from each. For less compliant individuals whose substance misuse is not yet very severe, it may be appropriate to train CMHT workers so that they are better able to detect substance misuse and have some basic skills in managing it. Specialist dual diagnosis teams or specialist workers within assertive outreach teams might then be reserved for the most challenging of the dual diagnosis clients.

In many countries, dual diagnosis is a clinically significant problem that may not be adequately addressed in current service planning. More comprehensive assessment is required of the overall needs for the care of people with dual diagnoses, together with rigorous evaluation of the costs and outcomes of the various strategies that might be used to provide them with integrated care.

EARLY INTERVENTION TEAMS

There has recently been a considerable impetus towards intervening early in the treatment of psychosis, and specialist teams for dealing with people in their first episodes, despite their rarity, have received a great deal of attention. The prime example of this sort of service is the Early Psychosis Prevention and Intervention Centre (EPPIC) in Melbourne [126]. There are three main reasons why we might wish to intervene as early as possible in the course of a psychotic illness. The first is common humanity: the requirement to curtail suffering does not require any special pleading. However,

the two other reasons do need to be substantiated. The second reason is that early treatment may improve outcome both for the episode and for the long-term course. Thirdly, effective early intervention may improve the attitudes of patients towards treatment.

Crucial to this debate is the question of when the course of psychotic disorder becomes set. This can be explored in various ways: examination of the overall course of illness, of the impact of florid relapse on overall course, and of the effect of treatment at different stages of the course.

Kraepelin [127] suggested a course characterized by gradual and enduring deterioration. However, it is not unusual to see patients who have a period of considerable disturbance in the early course of their psychotic illness, but who in later years show some amelioration and restitution of function. McGlashan and Johannessen [128] have concluded that, although some studies did show progressive decline, the majority suggested that there is little difference in populations of people with long-standing psychosis in the level of negative symptoms once the illness has lasted for a year or two.

The standard clinical view has been that a majority of patients develop social disabilities before the onset of florid psychotic symptoms and that an acute episode is superimposed against this background [e.g., 129]. However, the salience of negative symptoms seems greater after a first episode of positive symptoms than before. This suggests that negative symptoms may in some way be linked to the emergence of positive symptoms. This might be biological, and is usually assumed to be so. However, a psychological or psychosocial connection could be argued with equal plausibility [130]. Thus, the early period of positive symptoms may be critical for intervention.

In theory at least, it might be possible to reduce the development of negative symptoms and minimize the tendency for positive symptoms to relapse by intervening during this critical period. There is some evidence that the response to drug treatment is slower and less complete in later episodes [131, 132], although methodological problems limit the strength of this conclusion [133]. Other studies suggest that long duration of untreated psychosis (DUP) is associated with poor outcome. This has been found both in retrospective [134–137] and in prospective investigations [138, 139]. Despite attempts to control for other features associated with poor outcome, these studies remain open to the charge that DUP in any case reflects a worse form of disease. A further group of studies has examined outcome historically, that is, before and after the introduction of effective biological treatments: outcome genuinely seems to be better in younger cohorts [140, 141]. However, these cohort effects could be the result of influences other than better treatment.

The main problem in justifying early intervention is that the key study, an RCT of early and late intervention, has not yet been carried out because of ethical reservations. May *et al*. [142] have, however, reported on a follow-up

study of an RCT of treatment in first episode psychosis. Some of the patients had been allocated to a psychotherapy-only group, and they responded less well in the treatment phase than patients receiving drugs or electroconvulsive therapy. This implies that, in this first group, *effective* treatment was delayed on a random basis. As treatment was not controlled in the follow-up phase, these patients received pharmacotherapy later on. Nevertheless, at follow-up, their clinical state remained worse. This study seems to provide quite good evidence of an effect of (effective) early intervention, but, unfortunately, the subjects from the psychotherapy group still tended to have less in the way of drugs over the follow-up period. Recently the EPPIC group in Melbourne has published the results of a one-year follow-up of a study in which their local cognitive therapeutic approach was applied in the wake of a first psychotic episode. This treatment was directed more at adjustment to the fact of disease than towards positive symptoms of the disorder. There were three non-random comparison groups: those offered the psychological treatment who accepted and received it, those who refused it but were given other elements of the EPPIC package, and controls who, because they lived outside the catchment area, received only the EPPIC inpatient service. The results of this study were disappointingly negative [143].

The TIPS project [144] is currently the nearest approximation to an RCT of early and late intervention. It comprises one experimental sector and two control sectors. In the experimental sector there is an additional resource for early detection. However, in no sector is treatment delayed once a diagnosis of psychosis has been made. Results of this study will obviously be of enormous interest.

The current state of knowledge allows only tentative conclusions. It is possible that early intervention does affect the immediate, medium and long-term outcome of psychosis. Added to the humane argument for early intervention, this might justify the investment of resources in preferentially targeting people early in the course of their psychotic illness, partly on the basis of the precautionary principle. Even if early treatment, whether biological or psychological, does not directly improve outcome, it may do so indirectly by increasing engagement. This is particularly true for medication, where it may be possible to reduce the dosage required for effective treatment, to improve the experience of medication, and thus increase the likelihood that later treatment will be taken. Relapse rates in schizophrenia may be three times higher than they would be if all patients prescribed antipsychotics actually took them [145]. This is the compliance argument for early intervention [146].

It is generally accepted that teams devoted to early intervention should have not only additional resources but also additional expertise, which would centre on the delicate and negotiated management of antipsychotic

medication and the application of psychological techniques such as compliance therapy, CBT, and family interventions [132, 147, 148].

Once again the Department of Health in England and Wales has taken a lead in making the introduction of specialist early intervention teams a priority. However, the debate about the value of early intervention teams continues: it must take into account not only the absolute value of the approach, but also the cost–benefit and ethical issues of whether the necessary diversion of resources from people with more long-standing disorders should be accepted.

THE PRIMARY/SECONDARY CARE INTERFACE

The boundary between primary and secondary care shifts in relation to the service configurations in different polities. In some countries, few resources may be vested in primary care, while, in others, general practitioners (GPs) are the portal to the health system and carry out much of the less specialist care. This is particularly so in Britain, and the British system thus tests the limits of how much psychiatric care can be delivered by generalists. The answer is that when the care and treatment of severe psychiatric illness is located in primary care, there are often reservations about its sufficiency.

It is actually quite difficult to quantify case-loads of severe mental illness in primary care: some of this is definitional, but there are other obvious problems [149]. All in all, British data suggest that the average general practice list of 2300 would include eight or nine people with long-standing severe mental illness, but a new case would only be seen once every four years or so. Obviously, this would differ according to the location of the practice. In Britain, a quarter of patients with schizophrenia may be cared for *only* by the family doctor [150]. Patients who have had a single episode from which they have recovered form part of this group, but probably a small part. Pantelis *et al.* [151] found that, of patients in an inner London borough who had been seen by the secondary psychiatric services, only 60% were still in contact. Patients with disorganized lifestyles or acute illnesses may not even be registered with GPs [152].

In the recent British National Household Survey of Psychiatric Morbidity [153], only a third of patients with psychosis were receiving antipsychotics, and only 10% were receiving depot preparations. Fifty-three per cent were not receiving drugs of any kind, and 43% were not being treated at all. Eighteen per cent had used no services in the past year and a further 18% had been seen only by the primary care team. Thirty-seven per cent had not seen their GP in the last year. These figures are worrying, as they may mean that many patients are being cared for inadequately.

Nevertheless, there has been an increasing interest in the role of GPs in the management of long-standing schizophrenia over the last 10 years. It is still unclear what this role should be. Family doctors inevitably have some role in the psychiatric care of people with schizophrenia. In many cases, they will be the first to see someone who is developing schizophrenia, and their response is important, as early intervention *may* improve overall outcome [127]. They are also often involved at points of crisis. In general, family doctors are happy to provide investigation and management of physical problems and to prescribe medication, but feel that the psychiatric management of severe mental illness should primarily be the responsibility of the psychiatric team [154, 155]. A few with particular interest and expertise may become more involved in the direct provision of psychiatric care.

As indicated above, it is not uncommon for the primary care team to provide the only medical input for some patients. In most instances these will have relatively well-controlled symptoms, either completely in abeyance or interfering little with function. They require repeat prescriptions over long periods, occasional reassessment, and an avenue for contact with secondary services. However, in other cases, management solely by the GP is inappropriate, the situation having arisen because of imperfect follow-up procedures or because patients have detached themselves from the community psychiatric services. Thus, the decision to manage patients with schizophrenia solely within the primary care setting should be active: the situation should not arise by default.

In Britain, with its relatively well-developed system of primary care, there is a considerable governmental impetus towards developing care for people with severe mental illness that involves seamless integration between primary and secondary care. There must still be some doubt over how far this is feasible, and in countries with sparse primary care, the doubt will be major.

COMMUNITY CARE OF COMMON MENTAL DISORDERS (CMDs)

So far we have concentrated on severe mental disorders. These affect relatively few people, while disorders like depressive disorders and anxiety states are appreciably more common. Although they cause less disability than schizophrenia and severe affective disorder, they are not adequately captured in the phrase "the worried well", a term which has gained some currency in the last decade or so. While they may be worried, they are certainly not well: the World Bank study [156] estimated that the disability occasioned by depression was fourth among medical conditions and, by 2020, would be the second cause of illness-related disability, worldwide, as

other disorders recede. The World Health Organization (WHO) International Study on Psychological Problems in General Health Care [157] found that depression was responsible for nearly twice as much disability as arthritis, diabetes, back pain or hypertension.

The prevalence of common disorders is constrained by the criteria for the definitions used to capture them. In general populations, many people have a few symptoms and a few have many, so the cut-off point will have an important effect on prevalence and will take little account of the fact that people on either side of it have considerable similarities. The choice of case-finding instrument also has a major impact [158].

In spite of the uncertainty attached to case definition and case finding, there are probably genuine differences between locations in the prevalence of CMDs. These can be related in many cases in an understandable way to the level of hardship experienced by a population. Thus, rates of mental disorder in Canberra, the socially uniform and relatively affluent capital city of Australia, were considerably lower than in a deprived area of inner London [159, 160]. Very high rates of CMDs indeed have been recorded in sub-Saharan Africa [161, 162].

The major feature of the treatment of these disorders is that most are *not* treated, even in affluent developed nations. In the 15 centres involved in the WHO study, the percentage of those identified by primary care physicians as suffering from current depressive episode (ICD-10) who received an antidepressant varied between 0% and 46%, with a mean of 22% [163]. While this was worse in developing countries, it remained quite disappointing in countries with well-resourced systems of primary care. In Britain, the National Survey of Psychiatric Morbidity revealed a prevalence of ICD-10 depressive episode of 2.1% [164], and only 47% of people with ICD-10 depression had sought the help of their family doctor; of those, only 29% were prescribed an antidepressant [165, 166]. These figures, even if they are only approximations, indicate a significant level of unmet need for treatment of a condition that usually responds well to it.

Several factors are likely to contribute to this situation. They include a reluctance to seek help on the part of sufferers, whether through ignorance of the availability and appropriateness of treatment or a prejudice against it. Primary care physicians have shown a persistent tendency to fail in the identification of treatable mental disorders, despite considerable efforts in discovering the best methods of training them to do so. They also frequently decline to offer effective treatment to the patients they do recognise. Thus, GPs, too, have their prejudices and ignorance. Nevertheless, it is clear that mental health is a major public health problem within the primary care system, wherever located and however constituted [167]. The WHO collaborating team involved in the General Health Care Study remained convinced that mental health care should be an integral part of primary health services.

They recommended that, as sufficient information exists to frame effective training procedures, primary care workers from every discipline should have some level of training for dealing with common mental disorders [167]. It is clear that such initiatives are comprehended by the commitment of the WHO member nations to the target of ''health for all''. Achieving effective mental health care within the primary system will require consideration of local resources within their cultural and historical contexts: different situations will require different solutions, and it will not be easy.

CONCLUSIONS

In this chapter we have focused on ways of advancing community-based systems of mental health care, in relation particularly to the successful management of severe mental disorders. The goal of providing this through multidisciplinary teams is generally accepted, and yet the best way of doing it remains unclear. In particular, the choice between generic teams and teams with specific expertise is unresolved, perhaps because it is so dependent on local practice, local resources and the local cultural context. Innovative forms of service may not be generally exportable, but can nevertheless provide the basis for debates that may be locally fruitful. The uncritical adoption of someone else's practice may indeed be a pitfall to beware. It would not be surprising if social management techniques and procedures were strongly influenced by local conditions.

Attention to the structures and processes of treatment delivery should not blind us to the importance of the treatments to be delivered. It is our view that both family-based treatments and individual CBT hold considerable hope for people with severe mental illness.

The first decades of this century will be a test of commitment to community care by all the agencies involved: at the moment the spread of community services is patchy even in developed economies, and it will be interesting to see whether funding bodies provide adequate resources to change this situation.

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CHAPTER

7

Quality of Life: A New Dimension in Mental Health Care

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INTRODUCTION

While, for over a century, traditional psychiatry had concentrated on symptoms and diagnoses and had more or less neglected non-disease aspects of mental disorders, issues such as ''quality of life'', ''family burden'' and ''user satisfaction'' have become both practically and scientifically important over the last few decades.

One driving force behind this development in Western industrialized countries was, and still is, the fact that the systems of mental health care have undergone a fundamental change, with the main focus moving from institutionalized to community care. Aspects of the reality of everyday life, which had remained unnoticed or even suppressed in the traditional large mental hospitals, became relevant, not only to the general well-being of patients, relatives, friends and other network members, but also to the very course of psychiatric disorders themselves, which may show different patterns under community than under mental hospital conditions. The rise of the self-help and advocacy movement over the last few decades has also helped to bring quality of life issues to the forefront. Given the fact that in many countries the closure of mental hospitals has not been compensated for by establishing adequate community services, the quality of life concept has been applied not only to patients but also to the family members of the mentally ill, and is mainly represented under the ''family burden'' literature. Today, quality of life has become a topic, though often a controversial one, in everyday practical psychiatry.

From a scientific perspective, however, quality of life is an imprecise concept. It rather corresponds to a field of interest than to a unidimensional and easily measurable variable. In this respect it is not unlike the concept of

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disease, which also cannot be measured by a single variable. Nevertheless, the growing societal pressure to use the quality of life concept—even regulatory bodies tend to require that a new psychotropic compound improve not only symptoms but also quality of life—has led to problematic shortcuts in the development of assessment methods. Moreover, there is a substantial overlap between the quality of life concept and other concepts such as disability, social functioning, social support, or well-being [1]. Often, identical items appear in measurement instruments purporting to assess different variables, a fact which renders the interpretation of results of correlational analyses between these variables problematic.

Although the concept of quality of life is vague, or perhaps *because* it is vague, it has an intuitive appeal for many different parties who are involved in managing health and disease. Quality of life seems to be understood by everyone: patients, their family members, professionals—biologically oriented as well as psychosocially and sociologically oriented, the pharmaceutical industry and regulatory bodies, politicians and the general public. The concept of quality of life may consequently have a large integrative potential in a health care environment which is characterized by ever increasing conflicts and debates on costs and outcome. It provides a ''potential breath of fresh air'' in our understanding of health, illness and health care institutions [2]. This is especially true for psychiatry, where, in the case of patients with persistent mental illness living in the community, burnout in their carers and professionals can occur fairly quickly [3, 4]. The concept of quality of life as a primary target of helping activities—as opposed to mere symptom reduction and prevention of relapse—may help to unite forces and strengthen working alliances.

Albrecht and Fitzpatrick [2] have identified four uses of the quality of life concept in medicine: (a) as an outcome measure in clinical trials and health services research; (b) for the planning of clinical care of individual patients; (c) for health needs assessment of populations in descriptive studies; and (d) in health economic studies and for resource allocation. Most applications concern chronic and severe disorders.

The most promising use of the quality of life concept is as an outcome measure in clinical trials [5] and health services research [6]. There are problems, though, with the application of such measures in short-term clinical trials of psychotropic compounds, since changes in quality of life tend to need some time. The use of quality of life instruments in everyday clinical practice to improve clinicians' awareness of patients' disabilities and general well-being remains uncommon [7]. The health needs assessment of populations by quality of life measures has not yet produced results which are specific enough to indicate the requirement for specific health care interventions [8]. Finally, resource allocation by means of quality of life

measures is most controversial, not least because simplified global measures tend to be employed in this area [9, 10].

HISTORICAL BACKGROUND

In general language use, the term ''quality of life'' seems to have appeared first in the 1950s and was roughly equated with what one could call ''standard of living'', i.e. the economic and social determinants of well-being [11]. During the US presidential election campaign of 1964, Lyndon Johnson explicitly used the term: ''These goals cannot be measured by the size of our bank accounts. They can only be measured in the quality of life that our people lead'' [12].

The first documented use of the term in the medical literature seems to have been by an internist discussing problems of transplantation medicine in an editorial of the *Annals of Internal Medicine* [13]. Since then, the term has turned up more and more frequently in the medical literature. While a MEDLINE search for the year 1970 found five publications using the term, there were 284 such publications in 1980, 1399 in 1990 and 4597 in the year 2000. Most of these publications were related not to mental health topics but to somatic disorders, mainly chronic ones.

The quality of life concept has always been more popular in other medical disciplines than in psychiatry, despite the fact that pioneering work on the quality of life of long-term mentally disordered persons was carried out in the early 1980s [14–17]. Psychiatrists were probably hesitating because the mainstream concept of quality of life in medicine, with its emphasis on subjective well-being and satisfaction of the patient, is less separated from psychiatric concepts of mental disorders than it is from medical concepts of somatic diseases. In the latter case, quality of life was welcomed by many as a humanistic addendum to a more and more technocratic practice of medicine. As far as psychiatry is concerned, one could argue that the subjective well-being of the patient is psychiatry's proper topic or at least that it is intimately related to psychopathology. Psychiatry has also developed measures for non-medical aspects of diseases without calling them ''quality of life'' measures. Examples are ''social adjustment'' [18], ''disability'' [19], ''social functioning'' [20], and the assessment of patients' ''needs'' [21, 22].

Today, numerous papers on quality of life, concerning all types of physical and mental disorder, are published every year. Some are epidemiological studies, which describe the quality of life of community and clinical populations with specific disorders. Others present clinical trials and health services research (where ''quality of life'' is used as outcome measure), or economic studies of mental and physical diseases (for a comprehensive overview on

quality of life issues in mental disorders, including results on specific disorders, see Katschnig [23]). Many papers present new instruments and there is an ever growing literature on measurement techniques. In 1992, a scientific journal devoted entirely to health-related quality of life research was founded, and the International Society of Quality of Life Research held its eighth annual meeting in 2001. "Quality of life" has clearly become an established feature in medicine.

In 1948, without using the term "quality of life", the World Health Organization put forward its well-known definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" [24]; i.e., it gave somatic, psychological and social factors equal importance. Fifty years later, this sounds like an early definition of health-related quality of life. More recently, the World Health Organization jumped on the quality of life "bandwagon" and produced its own assessment instrument for quality of life (WHOQOL [25]). Furthermore, the World Health Organization has recently published an easy-to-use multiaxial presentation of the ICD-10 Classification of Mental and Behavioural Disorders which includes one axis on disabilities and another on contextual factors [26, 27; see also 28].

In addition to the comprehensive health definition of the World Health Organization, two other developments occurred, around the middle of the 20th century, which influenced the development of the quality of life issue in general and specifically alerted psychiatry to quality of life issues.

The more general development was the proposal by Maslow [29] of a hierarchy of human needs, starting with the most basic physiological needs (such as food and shelter) and going up to aesthetic and ethical needs and the need for autonomy. In relation to mental illness, one could argue that the way society has usually dealt with the mentally ill interfered with these basic human needs. While locking patients up in large mental hospitals at the beginning of the 20th century might have had the advantage of fulfilling the most basic needs—physiological needs like food, and security needs like shelter—human needs ranked higher in Maslow's hierarchy, like the need for autonomy, were neglected in this setting. On the other hand, at the end of the 20th century, in the era of community psychiatry, patients do have the possibility of gaining autonomy, but at the possible expense of not having fulfilled basic human needs. This is clearly a quality of life issue.

The other development, already mentioned, was triggered by the introduction of psychotropic medications in the 1950s, and consisted of the downsizing and closure of mental hospitals, which, in consequence, redirected the focus of psychiatry towards aspects of real life, instead of exclusively concentrating on disease issues, such as symptoms, diagnosis and relapse.

THE CONCEPT OF QUALITY OF LIFE

The concept of quality of life, as used in the literature, can best be regarded as consisting of three components: (a) subjective well-being or satisfaction with the actual life situation (whereby well-being would relate to emotions, and satisfaction to cognitions; both are subjective psychological concepts); (b) functioning in self-care and in social roles (''disability'' would be a variable measuring ''non-functioning'' in these roles); and (c) access to environmental resources, both social (e.g. social support) and physical (''standard of living'') [23]. While most instruments constructed in order to measure quality of life concentrate on subjective well-being and satisfaction, one can find all three components and their sub-aspects represented in various quality of life assessment instruments in the ever growing literature on mental health and quality of life.

Barge-Schaapveld *et al*. [30] have traced these three components back to three main research traditions. ''Well-being'' and ''satisfaction'' are rooted in psychology, more specifically in happiness research'', which appeared first in the 1950s [31]. The component of ''functioning'' goes back to health status research developed by social medicine and health sociologists in the 1970s, which aimed at assessing the effect of an illness and its consequent therapy upon the patient's functioning in daily life circumstances [32]. The component of environmental resources can be traced back to social indicator research, developed in the 1960s and 1970s by economists and sociologists who were studying inequalities between different groups within a given society and also between different societies [33].

Quality of life can best be conceptualized as the result of the interplay between all three components: subjective perceptions of one's well-being, objective functioning in self-care and social roles, and environmental opportunities, both social and material. Angermeyer and Kilian [34] have provided a useful overview of the theoretical models developed so far for conceptualizing this interplay. They distinguish the ''satisfaction model'' [14, 16], the combined ''importance/satisfaction model'' [35] and the ''role functioning model'' [15] and present their own ''dynamic process model''. The ''satisfaction model'' is criticized as being inconclusive about three ways to interpret ''high satisfaction'' with environmental conditions: is ''high satisfaction'' due to the fact (a) that there is a good fit between what people want and what they get, or (b) that the life domain in question is not important for a specific person, or (c) that people have lowered their aspiration standards over time (like the fox in the fable who cannot reach the grapes). While the combined ''importance/satisfaction model'' solves the problem raised by the just mentioned second possibility (it excludes life areas which are not important to the person), it fails to account for the objective environmental conditions a person is living in. The ''role function-

ing model'' accounts for these environmental opportunities, which consist of material and social opportunities; the latter are conceived as ''social roles'' through which people might satisfy their psychological needs, but which are also associated with demands or performance requirements. Angermeyer and Kilian's [34] own model is based on the assumption ''that subjective quality of life represents the results of an ongoing process of adaptation, during which the individual must continuously reconcile his own desires and goals with the conditions of his environment and his ability to meet the social demands associated with the fulfilment of these desires and goals. Within this model, satisfaction will not be regarded as the outcome, but rather as the steering mechanism of this process.'' In view of this complex situation, the authors conclude that quantitative research methods are of limited value in assessing quality of life in mental disorders, and that the already existing qualitative methods [36], which allow the recording of subjective meaning structures, should supplement the quantitative methods.

Existing assessment methods are usually not embedded in such a sophisticated theory and there is convergent criticism that quality of life research in general (not only in psychiatry) has so far been too concerned with measurement issues and psychometrics, at the expense of theoretical and conceptual development [37, 38]. This theory deficit becomes especially apparent when the aim is to assess quality of life in mental disorders, since the widely accepted position of concentrating on the subjective perspective of the patient within a satisfaction model [39, 40] is prone to measurement distortions. Barry [41] and Leff [42] have convincingly shown that, in psychiatry, such subjective assessment has to be complemented by objective evaluation.

Calman [43] has elegantly defined quality of life as ''the gap between a person's expectations and achievements'', which is basically a subjective concept. However, ''achievements'' depend not only on subjective factors, but also on the environmental possibilities offered. Assessing functioning in social roles, as some assessment instruments do, takes the environment partly into consideration. What is lacking in today's quality of life research is more of the social indicator research tradition, which builds environmental factors, social and material ones, into quality of life measures.

The need to include such contextual factors into the assessment of quality of life research is especially pressing in the case of psychiatric patients, where such factors interact with the patient's disorder more than in somatic problems. Income, social support and living conditions are intimately related to psychopathology. There are signs in quality of life research of a move towards going beyond subjective well-being and satisfaction by including assessment of functional status and environmental factors [44].

However, research on quality of life, in medicine in general as well as in psychiatry, is still largely dominated by assessing subjective well-being and patients' subjective view of their functioning in and satisfaction with different life domains, as a review by Lehman [45] shows.

Katschnig and Angermeyer [46] have developed an action-oriented framework for assessing quality of life in depressed patients, which includes well-being and satisfaction as psychological dimensions, as well as functioning and contextual factors as sociological dimensions (Figure 7.1). This model can be easily applied to other diagnostic categories. They show that helping actions have to be differentiated, since some act on psychological well-being (e.g., antidepressants), some on role functioning

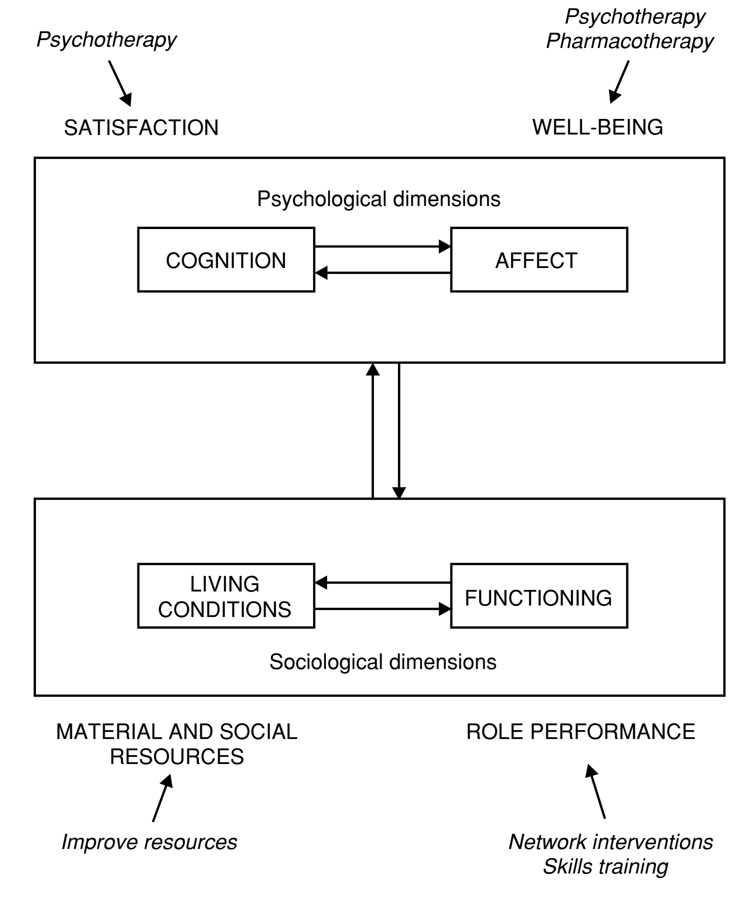


FIGURE 7.1 An action-oriented multidimensional framework for assessing quality of life in mental disorders. Modified from Katschnig [23]. Reproduced by permission.

(e.g., social skills training) and some on environmental circumstances (e.g., providing money). If quality of life assessment is to be action oriented, it has to be differentiated at least according to these three components of psychological well-being/satisfaction, functioning in social roles, and contextual factors.

Each of these three different components of quality of life has different time implications. Subjective well-being, which is largely dependent on the actual affective state, can fluctuate quickly; changes in functioning in social roles may take some time. Finally, environmental living conditions—both material and social—change only slowly in most cases. Thus, a depressed patient, whose subjective well-being declines quickly while depression is worsening, may still function in social roles. Even if this person does break down in functioning, the material living conditions and social support might still be unchanged for some time. However, once social functioning has deteriorated due to the long duration of the disease, and environmental assets, both material and social, have diminished, a patient might recover quickly in psychological well-being, but not recover quickly in social roles functioning. It will also take some time before environmental living conditions, both material and social, are re-established.

If ''quality of life'' is equated with ''subjective well-being'', then changes in ''quality of life'' might be observed after short psychopharmacological interventions. However, if functioning in social role is considered, the chances are less clear-cut that drugs might lead to quick improvement; and, finally, if social support and material living conditions are to improve again, it will probably take much longer and need other than psychopharmacological interventions.

A second, more complex time issue can best be described by the already discussed concept of Calman's gap between a person's expectations and achievements [43]. Which is more important: a good quality of life today or one tomorrow? In Calman's terms, should one keep the gap narrow now or tomorrow? There are numerous ways of achieving a short-term harmony between expectations and achievements, the use of psychotropic substances being the most common of these. In the long term, of course, substance abuse leads to a widening of this gap, following a vicious circle which implies decreased psychological well-being, loss of functioning in social roles, and deteriorating environmental and social living conditions. In psychiatry, it is known that long-term use of the traditional neuroleptics, which have embarrassing side effects, decreases relapse frequency, so that many patients are in the dilemma of having to choose between sustaining the side effects ''now'' or having an increased risk of relapse ''tomorrow''. Many prefer the ''better quality of life now'' to the ''better quality of life tomorrow'' and do not continue with this medication once discharged from hospital. The new antipsychotics, with a much more favourable side effect profile, will probably change this situation.

A further quality of life issue in relation to time concerns the influence of a long duration of a disorder on the subjective assessment of quality of life. It has been repeatedly observed that such patients adapt their standards downwards. One could call this phenomenon the ''standard drift fallacy'': if one cannot possibly achieve one's aims, these aims are changed.

Barry *et al*. [47] (see also Barry [41]) have demonstrated that patients who have lived for a long time in a psychiatric hospital are more or less satisfied with their lives (when satisfaction is assessed by a self-rating scale). Leff [42] reports that a substantial proportion of patients in two psychiatric hospitals were satisfied to stay there, but after having moved to community homes, did not want to go back into the hospital—probably as a result of the increased autonomy they re-experienced in the community, after having ''forgotten'' it while in hospital. Wittchen and Beloch [48] have shown that persons suffering from social phobia rate their quality of life as worse in the past than in the present, probably because they tend to be satisfied with what they have achieved, although this is far below the standards of the general population. A similar finding is reported by Davidson *et al*. [49] on persons meeting only sub-threshold criteria for social phobia—a closer look at the data showed that they had become disadvantaged in many respects, but did not find it worthwhile reporting this, since their social phobia had become their ''way of life''.

THE ASSESSMENT OF QUALITY OF LIFE

Quality of life assessment instruments are usually divided into two groups: generic and disease-specific instruments. The former have been developed to assess quality of life independent of a specific disease, the latter assess health-related quality of life in persons with specific diseases.

Generic instruments were the first to be developed. In the first phase of health-related quality of life research in the 1970s and early 1980s, already available psychological well-being scales were used or new ones were specifically developed for this purpose. This was in accordance with the main theoretical orientation of equating quality of life with subjective well-being. Examples are the Affect Balance Scale (ABS) by Bradburn [50], the Quality of Well-Being Scale (QWBS) by Kaplan *et al*. [51] and the Psychological General Well-Being Index (PGWB) by DuPuy [52]. This particular development has connections to the ''happiness research'' tradition within psychology, where well-being is discussed not only in terms of the absence of negative factors (like depressed mood), but as a positive concept [31, 53; see also 30, 46]. The use of these instruments in psychiatric patients is highly problematic, as will be discussed below.

From the 1980s onwards, in addition to the assessment of well-being and satisfaction, generic instruments for assessing functioning in daily life were

developed. This development is subsumed under the term ''health status research'' (see [30] for a more detailed discussion of the three roots of modern quality of life research). Well-known examples of ''health status research'' instruments are the Sickness Impact Profile (SIP [54]), the Nottingham Health Profile (NHP [55]) and the SF-36 [56]. Although these instruments do not use the term ''quality of life'', studies employing them are today generally regarded as belonging to health-related quality of life research.

Later, in contrast to these ''generic'' instruments, disease-specific quality of life instruments were developed. One well-known example is the European Organization for Research and Treatment of Cancer—Quality of Life Questionnaire (EORTC—QLQ) for quality of life research in cancer patients [57]. Today, literally hundreds of such instruments are available, so that it is difficult to keep an overview and to evaluate the quality of these instruments. In fact, the content of many of them seems to be quite arbitrary and not linked to any theory of quality of life, so that it is often difficult to know what is being measured. Updated overviews of these instruments have been regularly published in the journal *Quality of Life Research* and are now available electronically.

Specific instruments have also been developed for assessing quality of life in mental disorders. A list of such instruments discussed by Lehmann [45] is presented below, together with the most relevant references.

- Community Adjustment Form (CAF) [58, 59]
- Quality of Life Checklist (QLC) [60]
- Satisfaction with Life Domains Scale (SLDS) [14, 61]
- Oregon Quality of Life Questionnaire (OQLQ) [15, 62–65]
- Lehman Quality of Life Interview (QOLI) [16, 17, 66–78]
- Client Quality of Life Interview (CQLI) [79, 80]
- California Well-Being Project Client Interview (CWBPCI) [81]
- Lancashire Quality of Life Profile (LQOLP) [82, 83]
- Quality of Life Self-Assessment Inventory (QLSAI) [84]
- Quality of Life Index for Mental Health (QLI-MH) [35]
- Quality of Life Interview Scale (QOLIS) [85]

While most of the instruments in this list have been used to assess quality of life in persons living in the community and suffering from mental disorders in general (though these persons mostly suffered from schizophrenia), the following instruments have been developed for specific psychiatric disorders:

- Quality of Life Scale (QLS) [86] (specifically developed for schizophrenia)

- Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q) [87] (specifically developed for affective and anxiety disorders)
- SmithKline Beecham Quality of Life Scale (SBQOL) [88] (specifically developed for depression)
- Quality of Life in Depression Scale (QLDS) [89–91] (specifically developed for depression)

Many of these instruments can be critically discussed from a methodological point of view. Three such methodological issues will be discussed: the subjective vs. objective assessment issue, the multidimensionality of the concept, and the necessity to exclude psychopathological symptoms from quality of life measures.

"Subjective" vs. "Objective" Measures

The traditional focus of health-related quality of life research on patients' subjective experience is logically echoed by the predominant use of self-rating scales in this field. While this subjective approach to data collection is beginning to be regarded as problematic [92], it is still dominant today, not least in order to keep research costs low.

In psychiatry, reports about subjective well-being tend simply to reflect altered psychological states, as Katschnig *et al*. [93; see also 46] and Atkinson *et al*. [94] have shown for depression. In addition, reports by patients suffering from mental disorders about their functioning in social roles and about their material and social living conditions may be distorted for several reasons, described here as "psychopathological fallacies" [23]. There are at least three such fallacies which may distort both the perceptions by psychiatric patients of their quality of life and the communication of their perceptions to others: they are the "affective fallacy", the "cognitive fallacy" and the "reality distortion fallacy".

The most important of these fallacies is the affective one. It has been shown that people use their momentary affective state as information in making judgements of how happy and satisfied they are with their lives [95]. Depressed patients will usually see their well-being, social functioning and living conditions as worse than they appear to an independent observer [96] or to the patients themselves after recovery [97]. The opposite is true for manic patients who, quite naturally, rate their subjective well-being as very good, but also evaluate their social functioning and their environmental living conditions as unduly favourable. Mechanic *et al*. [78] have shown that depressed mood (in addition to perceived stigma) is a powerful determinant of a negative evaluation of subjective quality of life in schizophrenic patients. Both in research and clinical practice, the affective fallacy can lead to wrong conclusions. For instance, in internal medicine, quality of life

measures might disguise the presence of a comorbid depression which, as a consequence, might not be discovered and not be treated [92].

The reality distortion and cognitive fallacies are more readily recognized. At times, when patients suffer from delusions and hallucinations, perception of themselves and of their surroundings is distorted by these very symptoms. The cognitive fallacy concerns wrong evaluations by patients who are unable to assess intellectually their life situation, as is the case, for instance, in dementia and mental retardation.

Thus, while the patient's own view seems to be necessary, the question arises whether it is sufficient. Becker *et al*. [35; see also 98] contend that, in the field of psychiatry, quality of life assessment has to be carried out not only via the patient but also via professional helpers and key informants—as a rule, family members and friends of the patient. Becker *et al*. [35] accordingly provide a ''professional'' and a ''carer'' version of their Quality of Life Index for Mental Health (QLI-MH; later called the Wisconsin Quality of Life Index = W-QLI; see [98]). There is empirical evidence for this position: Sainfort *et al*. [99] have demonstrated that such assessments differ between patients and their relatives, and Barry and Crosby [100; see also 41] have shown that schizophrenic patients, when moved from a mental hospital to the community, showed no improvements in life satisfaction ratings, despite improved living conditions and increased leisure activities, which were assessed objectively. Patients who have suffered from schizophrenia over a prolonged period of time obviously tend to overestimate their level of functioning and environmental assets, while depressives tend to underestimate both [46, 96].

These observations warrant the conclusion that additional evaluations by professionals and by family members and friends are necessary to complement the patient's own subjective assessment. However, assessment by other persons is not per se objective and the term may be misleading. The term ''external assessment'' is probably more appropriate than ''objective assessment'', since even such assessment reflects the subjective view of the assessors themselves.

The quality of life assessment issue brings into the forefront a basic problem of psychiatry: how to reflect the different viewpoints which exist in society about whether a psychiatric disorder is present or not and whether something should be done about it or not. Most often there is disagreement in this matter between patients, their families and professionals, and such disagreement should at least be documented.

Multi-Area Assessment

A salient issue which is especially important in psychiatry is the use of a single quality of life index measure, as opposed to a quality of life profile

[101]. Both for the planning of interventions and for assessing outcome in clinical routine and in clinical trials, a structured, multidimensional use of the quality of life concept is necessary, i.e. different specific life domains, such as work, family life, money, etc., have to be assessed separately. Some psychiatric quality of life instruments separate such domains from each other [e.g., 35, 87], while others do not. For economic evaluations, a single index might be convenient, but this approach simplifies matters to such a degree that it becomes difficult or impossible to understand what the figure obtained actually means [see 10].

Recently developed instruments for assessing patients' needs are in fact multidimensional, like the CAN (Camberwell Assessment of Need [21]) and the NCA-MRC (Needs for Care Assessment instrument of the MRC-Unit in London [22]), implying that different actions are necessary for different needs in different life areas. A specific Management Orientated Needs Assessment instrument (MONA) following these lines has actually been developed in Vienna. This instrument also covers the possibility that the patient regards one life area as less important than another in terms of actions to be taken.

The Necessity to Exclude Psychopathological Symptoms from Quality of Life Measures

A third methodological issue that becomes especially salient in the mental health field is the fact that most quality of life instruments used in medical patients also contain "emotional" items, like depression and anxiety. Some authors even speak of an "emotional-function" domain. Here, the psychological tradition of measuring quality of life by "well-being measures" becomes tautological, since quality of life measures are necessarily correlated with measures of psychopathology, if the item content of both measures is largely overlapping—a clear case of measurement redundancy [46, 102].

One example is the use of quality of life as an outcome measure in clinical trials and evaluative studies. Given the lack of a clear-cut definition and the very broad concept of quality of life, there is a danger that therapeutic strategies are promoted on the basis of ill-demonstrated benefits for quality of life, since quality of life measures often include psychopathological symptoms. For instance, the Quality of Life Scale (QLS) by Heinrichs *et al.* [86], which was used in recent clinical trials of the new atypical antipsychotics, simply reflects the presence of negative symptoms. Another example is the Quality of Life in Depression Scale (QLDS) by Hunt and McKenna [89], which contains many depressive symptoms (see [46]). Such "measurement redundancy" is not uncommon in psychiatry. A remarkable

example is the Global Assessment of Functioning (GAF) Scale, included as Axis V in the DSM-IV. Meant to be used for assessing ''functioning'', it nevertheless contains psychopathological symptoms in such a manner that it is not possible to find out whether a specific score was given due to a high level of symptomatology or due to malfunctioning in daily life.

Stigma and Quality of Life in Long-Term Mental Disorders

For the long-term mentally ill, ''life satisfaction'' and ''quality of life'' necessarily include satisfaction with services. Oliver *et al*. [6] and Barry and Zissi [103] have provided useful overviews and discussions of the use of the quality of life concept as outcome measure. The issue is, however, more complicated than one might think at first glance. It is not enough to improve mental health services, because those suffering from long-term mental illness are confronted with a dilemma or paradox when they want to use services in order to improve their quality of life [104].

In brief, the dilemma consists in having to choose between two alternative no-win situations: either these persons accept help from services, by which they can improve their quality of life but are therefore stigmatized, or they refuse such help because they try to avoid stigma and consequently get no help from services [105].

The scientific discussions about the assumptions backing up this dilemma are not definite. Two schools of thought, one more psychiatrically, the other more sociologically minded, have mapped out the field for this discussion. The psychiatric quarters point out that stigma has no or only a short-lived influence on the course of mental disorders and that the benefit of services largely outweighs the possible disadvantages of a (non-existent or only short-lived) stigma. Sociologists, however, argue that once a person is known to suffer or have suffered from a mental disorder or merely to have used a psychiatric service, the consequences for the further course of the disorder are disastrous. The factual or anticipated discrimination in everyday life, the exclusion actually experienced by many persons suffering from a mental disorder [106], has negative influences on their self-esteem and self-evaluation and overtaxes their already reduced coping resources. Link *et al*. [107] have identified three coping strategies employed by persons suffering from mental disorders in order to avoid the negative consequences of stigma: (a) social withdrawal, (b) trying to conceal the fact of suffering (or having suffered) from a mental disorder or having used the respective services, and (c) trying to change people's opinions. Any of these three strategies would already overburden a healthy person's coping resources, and the more so in persons who have reduced resources and in whom these activities increase their susceptibility to a relapse or a chronic course.

According to this theory—the modified labelling approach—actual discrimination need not occur to set these preventive actions in motion. In a study testing the two hypotheses, Rosenfield [105] has found that both theories are right. Received services increase subjective quality of life, while perceived stigma reduces quality of life. The dilemma is still there.

CONCLUSIONS

The concept of quality of life is an intuitively plausible concept and probably very few would disagree that persons suffering from a mental disorder have the same right to the best quality of life as healthy people. The quality of life concept as a positive concept—as opposed to the negative concepts of symptoms and disease—has the potential of integrating otherwise discrepant opinions of the parties involved in dealing with mental health issues. It provides a ''potential breath of fresh air in our understanding of health, illness and health care institutions'' [2]. This is especially true for mental disorders and mental health care, which still mostly carry negative and pessimistic connotations.

Scientifically, however, quality of life is a difficult concept. ''Easy-to-use'' assessment instruments are often flawed and lack a theoretical background, although they are often presented with ''good psychometric properties''. Assessing quality of life is a complex issue, requiring a multidimensional approach that considers subjective satisfaction and well-being as well as functioning in self-care and in social roles, and also the environmental opportunities, social and material, of the person in question. Various life areas, which may be of different and even changing importance for different persons, have to be kept separate. And, finally, it has to be kept in mind that persons suffering from long-term mental disorders tend to lower their standards, a fact which explains why ''life satisfaction'' and ''quality of life''—if assessed by simple quantitative measures—are astonishingly high, although everyone else would agree that quality of life is reduced in this population. We conclude that, if the quality of life approach is to become more relevant to practical mental health care, quantitative measures will have to be supplemented by the already available qualitative methodological approaches [108].

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CHAPTER

8

Mental Health Problems in Refugees

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INTRODUCTION

Since Biblical times, refugees and internally displaced persons have been part of the history of civilization. Populations have been driven out of their countries and regions to far-off places, due to war, famine, persecution, and other natural and man-made calamities.

Currently, there are numerous regions of the world which face the massive task of resettling large numbers of refugees. Africa, South East Asia and Europe are some of the regions which are trying to cope with the pressures of these groups of population.

Refugees and internally displaced persons not only suffer the trauma of being suddenly uprooted from a known environment, but also face the daunting tasks of coping with a new place, new culture, and new people, in addition to the primary problems of food, shelter, clothing. The daily struggle for survival leaves its mark on both the physical and mental health of refugees and internally displaced persons. Undoubtedly, the issue of survival takes precedence over the issue of mental health, but nowadays more and more people are coming to understand the value of mental health issues in this group of people. Understanding the mental health problems and taking adequate measures to prevent and minimize them are being seen as cornerstones for the overall improvement of the health of the people. The impact of stress on mental disorders has been discussed for a long time and there is an established model for studying this in mental health problems observed among refugees and internally displaced persons.

Since there are several terms used to describe people forced out of their usual communities, we give here the definitions that have been used in this chapter.

Refugees. According to the 1951 convention relating to the status of refugees, ''refugees'' are persons who, owing to a well-founded fear of persecution for reason of their race, religion, nationality, political opinion or membership in a particular social group, are outside the country of their nationality and are unable to or, owing to such fear, are unwilling to avail themselves of the protection of the country [1].

Internally displaced persons. ''Internally displaced persons'' (IDPs) are individuals or groups of people who have been forced to flee their homes to escape armed conflict, generalized violence, human rights abuse or natural or man-made disasters [2].

Civilians become recognized as ''refugees'' when they cross a national border to seek sanctuary in another country, whereas IDPs remain in their own state. While refugees are protected by international organization and laws and conventions, there are no such laws or conventions for IDPs. They are left in the hands of the national government, which sometimes treats them as ''enemies of the state''. Moreover, it is difficult to get international help to them. However, the problems of refugees and IDPs remain quite similar and solutions for both are similar except for the magnitude and feasibility of providing assistance. Often the reintegration of returning refugees also requires the assessment of IDPs, as was (or is) the case in Mozambique, Sierra Leone, Afghanistan and Guatemala [2].

This chapter deals with the mental health problems of asylum seekers, refugees, internally displaced and repatriated persons, and other non-displaced populations affected by war and organized violence. This follows an example set by a recent editorial [3].

THE DIMENSIONS OF THE PROBLEM

The problem of increasing number of refugees and IDPs is one that we are facing more often in recent times. As wars rage across the world, millions of people are forced to flee their regions and assume refugee status in a new country, or become IDPs.

In January 1999, it was estimated that there were 50 million refugees and displaced persons worldwide. Of these, only 23 million were protected and assisted by the Office of the United Nations High Commissioner for Refugees (UNHCR). The current lack of international consensus over legal definitions deprives the remaining 27 million people of the same support [3]. Although the Special Representative of the UN Secretary General for IDPs estimates that there are 20–25 million IDPs, figures as high as 30 million have been quoted.

It is estimated that 5 million of these refugees were already suffering some mental disorder prior to the war or calamity and another 5 million had suffered some psychosocial dysfunction. Since accurate figures are not available, these estimates are only approximations, but it is quite likely that a substantial proportion of refugees present mental health problems that range from chronic mental disorders to trauma, distress and mental suffering.

The effects of war, torture, and disaster on the mental health problem of refugees are manifested in several ways, including adjustment problems, depression, anxiety disorders or post-traumatic stress disorder (PTSD). The stressful condition of a refugee could even worsen any underlying mental disorders such as psychotic illnesses.

There have been many studies on refugees and populations in exile to assess their mental health problems. Studies have been done in countries where refugees have settled and also in conflict areas.

Studies Conducted in Areas Where Refugees Have Settled

Clinic-Based Studies

Mollica *et al*. [4], studying an Indo-Chinese group of patients in their clinic, found that 36% suffered from affective disorders, 1.9% from PTSD, 58% from affective disorders and PTSD, and 7.3% from other psychiatric disorders. Kinzie *et al*. [5] found that, out of 322 Indo-Chinese patients surveyed, 81% suffered from depression, 16% suffered from schizophrenia and 75% fulfilled a current diagnosis of PTSD. Lavik *et al*. [6] found PTSD in 48%, affective disorders in 16%, adjustment disorders in 10% and anxiety disorder in 6% of the group of refugees surveyed by them in an outpatient clinic in Oslo, Norway. These studies have been summarized in Table 8.1.

Community-Based Studies

Besides clinic-based studies, there have been many community-based studies of refugees. Sundquist [7] found that 18.3% of Latin-American refugees had some psychological distress compared with 2.8% of the control population of Swedes. Cheung [8] found 12.1% of the 223 Cambodian refugees surveyed by him to be suffering from PTSD. Sack *et al*. [9] conducted a community survey including 209 randomly selected Khmer youths and a parent from two communities. With standardized instruments like the

TABLE 8.1 Clinic-based studies of mental disorders in refugees (in countries where the refugees had settled)

Country	Subjects and methods	Prevalence (%)	Reference
USA	52 Indo-Chinese refugees Life Events and Social History Questionnaire, HSCL-25, DIS Follow-up	36 (affective disorder) 1.9 (PTSD) 58 (PTSD and affective disorder)	Mollica *et al*. [4]
USA	322 Indo-Chinese refugees DSM-III Cross-sectional	81 (depression) 16 (schizophrenia) 75 (PTSD)	Kinzie *et al*. [5]
Norway	231 refugees from different countries Cross-sectional BPRS, HSCL-25, PTSS-10	48 (PTSD) 16 (dysthymia and depression) 10 (adjustment disorder) 6 (anxiety disorder) 20 (other mental disorder)	Lavik *et al*. [6]

HSCL-25: Hopkins Symptom Checklist, 25 items; DIS: Diagnostic Interview Schedule; BPRS: Brief Psychiatric Rating Scale; PTSS-10: Post-Traumatic Stress Symptoms 10-item checklist.

Diagnostic Interview for Children and Adolescents (DICA) [10] and the Schedule for Affective Disorders and Schizophrenia for School Age Children (KSADS) [11], it was found that, whereas among the youths the point prevalence was 18.2% for PTSD and 11% for depressive disorders, the parents showed a much higher point prevalence—53.2% PTSD and 22.2% depression in mothers and 29.4% PTSD and 23.4% depression in fathers. Comorbidity was also higher among the parents than in their children. In Thailand, Allden *et al*. [12] studied 104 Burmese political prisoners and found that 38% had elevated scores for depression and 23% for PTSD. Drozdek [13] found PTSD in 44% of the Bosnian refugees surveyed by him. In a prospective study over a 2-year period, Beiser and Hyman [14] found the prevalence of depression to decrease from 6.4% to 3.1%, in 1348 South East Asian refugees settled in Vancouver. The prevalence of mental disorders among a group of Central American refugees in the USA was also found to be very high—PTSD 68%, generalized anxiety disorder 8%, social phobia 12% and simple phobia 16% [15]. Holtz [16] found that 41.4% and 14.3% of a group of Tibetan nuns and students in India suffered from anxiety and depressive symptoms, respectively. Blair [17], while conducting a survey on Cambodian adults settled in the Salt Lake City (USA) region, found PTSD and major depression to be present in 45% and 51% of the surveyed group, respectively. These studies have been summarized in Table 8.2.

TABLE 8.2 Community-based studies of mental disorders in refugees (in countries where the refugees had settled)

Country	Subjects and methods	Prevalence (%)	Reference
Sweden	338 Latin American refugees, 161 South Europeans, 396 Finnish labour migrants, 996 Swedish controls Cross-sectional Swedish Annual Level of Living Survey Questionnaire	Psychological distress: 18.3 (Latin American) 6.1 (South European) 4.3 (Finnish) 2.8 (Swedish controls)	Sundquist [7]
New Zealand	223 Khmer refugees Cross-sectional HTQ, DIS, GHQ-28	12.1 (PTSD)	Cheung [8]
USA	209 Khmer youths and a parent Cross-sectional (point prevalence) DICA, KSADS	Adolescent: 18.2 (PTSD) 11 (depressive disorders) Mothers: 53.2 (PTSD) 22.2 (depression) Fathers: 29.4 (PTSD) 23.4 (depression)	Sack *et al*. [9]
Thailand	104 Burmese refugees Cross-sectional HSCL-25, HTQ	38 (depression) 23 (PTSD)	Allden *et al*. [12]
Netherlands	120 Bosnians Cross-sectional DSM-III-R	44 (PTSD)	Drozdek [13]
Canada	1348 South East Asian refugees Follow-up DSM-III-R	Initial: 6.4 (depression) After 2 years: 3.1 (depression)	Beiser *et al*. [14]
USA	50 Central American refugees Cross-sectional ADIS-R, HRSD, HARS	68 (PTSD) 16 (simple phobia) 12 (social phobia) 8 (GAD)	Michultka *et al*. [15]
India	35 Tibetan nuns and lay students and 35 controls Cross-sectional HSCL-25	41.4 (anxiety symptoms) 14.3 (depressive symptoms)	Holtz [16]
USA	124 randomly selected Cambodian refugees Cross-sectional DIS, DICA	45 (PTSD) 51 (depression)	Blair [17]

HTQ: Harvard Trauma Questionnaire; GHQ-28: General Health Questionnaire, 28 items; DICA: Diagnostic Interview for Children and Adolescents; KSADS: Schedule for Affective Disorders and Schizophrenia for School-Age Children; ADIS-R: Anxiety Disorders Interview Schedule—revised; HRSD: Hamilton Rating Scale for Depression; HARS: Hamilton Anxiety Rating Scale.

Studies Done in Conflict-Affected Areas

It is obviously more difficult to carry out any epidemiological study in a conflict-affected area. However, there are some important surveys done in these or nearby areas. These have been summarized in Table 8.3.

In Guinea-Bissau (West Africa), de Jong [18], while evaluating 351 adults seeking help in rural or urban settings, found that 12% suffered from some form of mental disorder, of whom 74% had neurotic illnesses and 13% psychotic illnesses. Somasundaram *et al*. [19] found that, among Cambodian help-seekers, 18% had schizophrenia, 15% psychosis, 18% anxiety disorder, 14% depression and only 3% PTSD. Mollica *et al*. [20] found PTSD in 15% and depression in 55% of the Khmer refugees they surveyed. Bowen *et al*. [21] found 41% of their surveyed group of Salvadorean women to be suffering from PTSD. Somasundaram and Sivayokan [22] found that in a Sri Lankan community 27.5% suffered from PTSD, 26% generalized anxiety disorder and 25% major depression. Shrestha *et al*. [23], while comparing a group of tortured Bhutanese refugees with a non-tortured refugee group, found mental disorders to be significantly more prevalent in the former group. Rasekh *et al*. [24] found PTSD and depression to be present in 42% and 97% of the Afghan women they surveyed. Peltzer [25], while studying a group of Sudanese refugees settled in camps in Uganda, found that 32% of the adults and 20% of the children were suffering from PTSD. Mollica *et al*. [26] found that among a group of Bosnian refugees settled in Croatia, 39.2% had depression, 26.3% PTSD and 20.6% comorbid disorders. Lopez Cardozo *et al*. [27] found PTSD in 17.1% and non-specific psychiatric morbidity in 43% of Kosovar Albanians. De Jong *et al*. [28] also found a 50% prevalence of serious mental health problems in Rwandan and Burundian refugee camps in Tanzania.

SPECIFIC DISORDERS AMONG REFUGEES

Though the prevalence of different disorders varies widely across studies done on refugee populations, some disorders stand out as being more prevalent among the group. These are PTSD, affective disorders, anxiety disorders and adjustment disorders. Psychotic disorders and disorders related to child and adolescent population and other non-specific psychosocial problems are also prevalent to an increasing degree among this group of the population.

Post-Traumatic Stress Disorder (PTSD)

Mental disorders related to severe stresses were first recognized during the American Civil War, when, in 1875, Da Costa identified the irritable heart

TABLE 8.3 Community-based studies of mental disorders in refugees (in conflict-affected areas)

Country	Subjects and methods	Prevalence (%)	Reference
El Salvador	31 women refugees Cross-sectional DSM-III-R	41 (PTSD)	Bowen *et al.* [21]
Thailand	993 Khmer refugees in Thai camp Cross-sectional HSCL-25, HTQ	15 (PTSD) 55 (depression) 11 (suicidal feelings)	Mollica *et al.* [20]
Sri Lanka	98 residents selected randomly Cross-sectional SIQ	27.5 (PTSD) 26 (GAD) 25 (depression)	Somasundaram and Sivayokan [22]
India	526 tortured Bhutanese and equal number of non-tortured refugees Case-control DSM-III-R, HSCL-25	Tortured refugees/ non-tortured 14/3 (PTSD) 25/14 (depression) 43/34 (anxiety)	Shrestha *et al.* [23]
Afghanistan	160 randomly selected women Cross-sectional DSM-IV, HSCL-25	42 (PTSD) 97 (depression)	Rasekh *et al.* [24]
Uganda	279 refugees Cross-sectional HSCL-25, HTQ, PTSD-QC	Adults/children 32/20 (PTSD)	Peltzer [25]
Croatia	534 randomly selected Bosnian refugees Cross-sectional HSCL-25, HTQ, MOS SF-20, WHO Physical Functioning Scale, DSM-IV	26.3 (PTSD) 39.2 (depression) 20.6 (PTSD and depression)	Mollica *et al.* [26]
Kosovo	1358 randomly selected Albanians Cross-sectional GHQ-28, HTQ, MOS SF-20, DSM-IV	17.1 (PTSD) 43 (non-specific mental morbidity)	Lopez Cardozo *et al.* [27]
Tanzania	854 randomly selected Burundian and Rwandan refugees Cross-sectional GHQ-28	50 (serious mental health problems)	de Jong *et al.* [28]

PTSD-QC: PTSD Questionnaire for Children; MOS SF-20: Medical Outcome Study 20 Items Short Form.

syndrome described by soldiers of that war. Experiences gathered from the Vietnam War eventually led to incorporation of PTSD in the DSM-III.

According to the DSM-IV, PTSD requires some basic criteria to be fulfilled: exposure to a traumatic event which is then persistently re-experienced through recollections, dreams, and cue-related psychological and physiological distress; avoidance of stimuli associated with the trauma; numbing of general responsiveness; and persistent symptoms of increased arousal, all of which together cause clinically significant distress or impairment in social, occupational or other functioning. The ICD-10 provided a different stressor criterion: a situation or event ''of exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone''. It differs from the DSM-IV in that symptoms of increased arousal are not invariably required and may be replaced by the inability to recall important aspects of the trauma.

Many epidemiological studies done on refugee populations across different cultures, sexes and age groups have shown PTSD to be highly prevalent. PTSD prevalence among help-seeking refugees has varied from 48% [6] to 75% [5]. Among community samples, Cheung [8] found PTSD in 12% of Khmer refugees settled in New Zealand; Drozdek [13] found 44% of Bosnian refugees in the USA to be suffering from PTSD; Michultka *et al*. [15] found a 68% prevalence of PTSD in Central American refugees; Fox and Tang [29] estimated a 49% PTSD prevalence in a Sierra Leonean refugee population; and Blair [17] found 45% of the Cambodian refugee group surveyed by him to be suffering from PTSD. In conflict areas, PTSD figures were equally high and Somasundaram [30] found a 63% PTSD prevalence in a refugee group subjected to aerial bombing 1–2 months earlier. Studies including women [21] or the studies done on child and adolescent populations have shown a very high prevalence of PTSD, too.

Sack *et al*. [31] found that, among a group of Khmer refugees, arousal, avoidance, intrusive thoughts and numbing were all present. ''Koucharang'', defined as ''thinking too much'', was identified as a culture-bound syndrome in response to violence experienced in Cambodia [32]. Asian refugees had been found to express distress in the form of somatic complaints by Chung and Singer [33] and D'Avanzo and Barab [34]. Shrestha *et al*. [23] found Bhutanese refugees suffering from PTSD to have significantly higher levels of distressing dreams of the event, avoidance, psychogenic amnesia, diminished interest in activities, detachment from others, restricted affect, hypervigilance and physiological arousal. Depression was found to have an important contribution to traumatic response in different studies, and the contribution of depression comorbid with PTSD was found to increase the risk of suicidal behaviour [35–37].

Although PTSD has been diagnosed across different cultures, there is a school of thought arguing that many of the diagnoses of PTSD are wrong, an

error of extrapolating Western concepts to other cultures. Eisenbruch [38, 39] has argued that, among Cambodian refugees experiencing symptoms akin to PTSD, ''cultural bereavement'' could better account for the symptoms. Cambodian refugees may regard their perceived abnormality in body or brain as caused by malevolent mystical or animistic forces in the new country or deliberate interference by magicians and sorcerers. They continue to show features of distress due to loss of social structure, cultural value and self-identity, by living in the past, suffering feelings of guilt, experiencing pain and having constant images from the past intruding into daily life in dreams and during the day. Urges to fulfil obligations to the dead, morbid thoughts, anxiety and anger can be associated with it. These features, along with psychosomatic symptoms of headache, lethargy and worry, form culturally accepted features of bereavement, but are not features of PTSD. Eisenbruch [38] has suggested that cultural bereavement is constructive and helps in rehabilitation after devastatingly traumatic experiences.

Summerfield [40] has criticized the overinclusion of subjects into the rubric of PTSD. He has argued that in many trouble-torn countries children are seen fighting mock battles, carrying out mock executions or otherwise revealing preoccupation with first-hand experiences of death, destruction, starvation and violence. But these are not symptoms of PTSD.

All these criticisms of the universalist concept of PTSD could also explain the low disability rate found in different refugee groups across the world [26, 29, 30, 41–44].

Although the validity of PTSD as a diagnosable disorder is not in doubt, its magnitude, its predominant position as the sole or main consequence of serious traumatic events in diverse cultures and its public health significance are open to question. PTSD should be regarded as one of the mental disorders in the aftermath of severely traumatic events, together with other disorders like anxiety and depressive disorders. More importantly, the presence or absence of PTSD should not be taken as evidence for or against the validity of negative experiences that the person may have faced or the need for psychiatric help. The use of PTSD as an indicator for mental health care needs across cultures should not be attempted in view of cultural differences for this diagnosis.

Affective Disorders

Although the lifetime risk of major depressive disorder in the general population is 10–15% for women and 5–12% for men, the prevalence of depression among refugees is higher. There is a wide variance across studies, with values ranging from about 15% to as high as 80%. In spite of

this wide variance in prevalence, it is reasonably certain that depressive disorders are one of the most common mental disorders among refugees and IDPs. The disorders may be of a low-grade prolonged type (dysthymia) or be more severe but shorter in duration (major depressive disorder). At times, there may not be a manifest disorder but only certain symptoms of depression like sadness, lethargy, low mood, fatigue and headache. Although the majority of the studies have reported just the prevalence of major depressive disorder, some have listed symptoms that were found to be more common in some cultures, and that reflected cultural manifestation of depression. Asian refugees have been found to report somatic rather than affective symptoms [45]. Headache was found to be the commonest expression of depressive symptoms in some studies [46]. Certain cultural expressions of sadness, such as ''Bebatchel''—a culture-dependent depressive state indicating ''a deep worrying sadness not visible to others''—or ''Khuocherang''—a tendency to worry about or ruminate over past events—have been used by Cambodian refugees to express depressive feelings [34, 41]. Depressive symptoms have been found to be related to the recency and frequency of trauma [47].

Among refugee populations, certain social factors have been found to be related to depressive or other mental disorders. Lavik *et al*. [6] found that refugees who had been granted ''political asylum'' were better off than those granted ''permission to stay on humanitarian grounds''. This is understandable, as the latter status means limited rights and also implies reduced public acceptance. Unemployment, loss of meaningful structure and activity in life, inadequate proficiency in language of the host country, and conflicts with children are other indicators linked with depression [48, 49]. Certain factors, such as being married, have been found to enable people to cope better with depression in the same study. Among the Tibetan refugees surveyed by him, Holtz [16] found that Buddhist spirituality helped in the development of protective coping mechanisms.

Anxiety Disorders

Anxiety disorders, like the generalized anxiety disorder and phobic disorders, have been found to have a high prevalence among refugee groups. The prevalence rates have varied from 5% to 43% in a study done on Bhutanese refugees settled in India [23]. Somasundaram [30] found rates of 58% for phobic symptoms, 17% for panic disorder and 19% for generalized anxiety disorder in a group of Sri Lankan refugees surveyed 4–9 weeks after an attack of aerial bombing. Across studies, the prevalence rates have varied due to the latency of time and severity of trauma, as pointed out by Mollica *et al*. [47]. One study done by Silove *et al*. [50] found that anxiety

scores were correlated with female gender, poverty, conflict with immigration officials, loneliness and boredom.

Adjustment Disorders

Adjustment disorders have been defined in the ICD-10 as states of subjective distress and emotional disturbance, usually interfering with social functioning and performance, and arising in the period of adaptation to a significant life change or to the consequences of a stressful life event (including the presence or possibility of serious physical illness). The stressor may have involved the individual or his community.

The DSM-IV suggests that the essential feature of an adjustment disorder is the development of clinically significant emotional or behavioural symptoms in response to an identifiable psychosocial stressor or stressors.

The distress suffered by a person should be in excess of what is expected as a normal reaction to the stressor. It may be manifested as predominantly depressive or anxiety symptoms, a mixture of depressive and anxiety symptoms, or disturbances of conduct or emotion. As pointed out by the ICD-10 categorization under which adjustment disorder is incorporated—''reaction to severe stress, and adjustment disorders''—stress is the hallmark of this group of disorders.

For the refugee population, stress may be experienced at every step, starting from the destruction of life and property as a result of war, the problems faced in shifting from one place to another and often to a new country, the pressures of coping with a new culture and language, the difficulties in relocation and ultimate absorption into another country, and the daily hardships faced in temporary refugee camps.

As a result of this continuous series of stresses, refugees manifest many emotional problems, like frequent quarrels, frustration, despair, sadness, anxiety and bereavement. What may start as bereavement and sadness for the loss of life and property may eventually change to an adjustment disorder or a depressive disorder. Sometimes the initial trauma can be strong enough to lead to a transient disorder of significant severity called acute stress reaction, which gradually develops into a more prolonged adjustment disorder.

During the course of the disorder, the person may have temporary difficulties in maintaining a relationship, have problems in rationalizing and reaching a decision, or have periods of depressive and anxiety symptoms. Depressive symptoms in the face of prolonged stress can be severe enough to lead to suicide. Generally, adjustment disorders last for a maximum of 6 months, but the disorder may be prolonged if the symptoms are predominantly depressive in nature of if the stressors continue.

Schizophrenia and Other Psychotic Illnesses

There have been a few studies that have looked at this issue. Kinzie *et al.* [5] found schizophrenia in 16% of the Indo-Chinese refugee population, similar figures were found among Cambodian refugees by Somasundaram *et al.* [19], and a slightly lower figure of 13% was found in refugees in Guinea-Bissau by de Jong [18].

Lavik *et al.* [6] opined that stress and traumatization connected with the refugee situation itself do not have a decisive impact on the development of psychotic symptoms, which may instead be related to other conditions or constitutional factors. However, certain traumatic experiences, like sensory deprivation, can cause psychotic symptoms. The stress–vulnerability model of schizophrenia also suggests a link between stress and schizophrenia in susceptible persons. So it is not unusual to find a higher prevalence of psychotic illnesses in refugee populations, though studies are lacking on the time of onset of the disorder, making it difficult to attribute to the refugee status the high prevalence of psychotic illnesses.

Disorders in Child and Adolescent Population

Children form one of the most vulnerable groups among refugees. Often they are the neglected lot. Psychiatric problems among refugee children are more prevalent than among the normal population of the same age. Although it has been argued that children are able to cope much better than adults, the fact remains that a large number of children among the refugee population suffer from mental disorders. Studies reveal that children, like adults, suffer an increasing number of psychiatric problems, among which PTSD, depression, anxiety and conduct disorders are the commonest ones.

In Finland, Sourander [51] found that 48% of the surveyed refugee children had symptoms of PTSD, depression or anxiety. Fox *et al.* [52] found depression in 51% of the South East Asian refugee children surveyed by him in the USA. Sack *et al.* [53] conducted a long-term study using standardized instruments to assess the prevalence of PTSD and depression in a group of Cambodian children. They found that over a 12-year period the point prevalence for PTSD decreased from 50% to 35%, and that for depression dropped from 48% to 14%. Psychosocial problems were more prevalent than mental disorders in a group of refugee children studied in the UK [54].

Numerous children become innocent victims of war. Some lose their parents and relatives, some lose friends, schooling is disrupted and childhood is lost. In many areas, children are inducted as soldiers. According to the Machel Report [55], nearly a quarter of a million child soldiers saw

armed conflict in the late 1980s. Children are often forced to work as messengers, porters, and cooks or even to provide sexual gratification to older soldiers. They are often picked up from the streets or forcibly taken from their poor and frightened families by the leaders or chosen from the unaccompanied children. Unfortunately, all this leads to an increase in the prevalence rate of mental disorders among children caught in conflict areas.

In this context, Schwarzwald *et al*. [56] conducted a survey among Israeli children from areas hit by missiles and compared them with children from areas not hit by missiles. The prevalence for PTSD was 24.9% in the former area and 12.9% in the latter. However, social functioning was found to be relatively preserved. Mollica *et al*. [57] surveyed 182 Khmer children settled in Thai refugee camps and found that 53.8% had psychiatric symptoms as per parent report on the Child Behaviour Checklist [58] and 26.4% on the Youth Self-Report [59]. PTSD was found in 945 of internally displaced Bosnian children in another survey [60]. In the Gaza Strip, Thabet and Vostanis [61, 62] found that out of the 959 children surveyed by them 44% showed ''caseness'' on the Rutter B2 scale [63], and 26.8% in the parent rating scale [64], with a cut-off score of 9. PTSD was again found to be an important disorder.

Sack *et al*. [53] found almost half of the surveyed Khmer adolescents to be suffering from PTSD and depression in their initial assessment. The rates decreased to 35% for PTSD and 14% for depression after 12 years of follow-up. Servan-Schreiber *et al*. [65] found both PTSD and depression in 11.5% of the Tibetan children. Rates as high as 95% and 90% for PTSD and anxiety, respectively, have been found in displaced Bosnian children by Stein *et al*. [66]. However, all diagnoses of PTSD have to be judged carefully, keeping in mind the huge cultural difference across communities and the meaning and manifestations of trauma across different cultures.

Children end up as refugees with or without their families. They are either willing or unwilling participants in a war and often have experienced death and destruction. At times they have been the cause of death, as soldiers, or have been tortured physically or sexually. Once in a foreign land, children express some coping behaviour that is culturally determined and some other that they gradually develop. Children are quicker to absorb the new culture, make friends and learn the new language. Often their ability to assimilate faster into a new community leads to a change of role in their home, and adults tend to depend on them more for help in resolving social issues. Although there are studies showing very high prevalence rates for mental disorders, especially PTSD, there are others [40] that have criticized the overdiagnosis of PTSD by Western assessors, including the international organizations. Studies related to mental health problems among children and adolescents are summarized in Table 8.4.

Table 8.4 Studies on children and adolescents

Country	Subjects and methods	Prevalence (%)	Reference
Israel	492 schoolchildren whose areas were hit by missiles and controls Cross-sectional Stress Reaction Questionnaire, DSM-III-R, teacher's rating	Affected/controls 24.9/12.9 (PTSD)	Schwarzwald *et al.* [56]
Thailand	182 Khmer children Cross-sectional Child Behaviour Checklist, Youth Self-Report	53.8 (psychiatric symptoms as per parent report) 26.4 (psychiatric symptoms as per youth report)	Mollica *et al.* [57]
Former Yugoslavia	364 internally displaced children Cross-sectional Bosnian War Questionnaire, Sead Picture Survey Tools	94 (PTSD)	Goldstein *et al.* [60]
Finland	46 unaccompanied refugee children Cross-sectional Child Behaviour Checklist	48 (symptoms of depression, anxiety or PTSD)	Sourander [51]
Former Yugoslavia	147 children in collective centres Follow-up over 8 months DSM-IV	Initially: 95 (PTSD) 90 (anxiety) At 8 months: boys showed greater decrease of symptoms in relation to girls	Stein *et al.* [66]
India	61 randomly selected Tibetan children Cross-sectional DSM-IV	11.5 (PTSD) 11.5 (depression)	Servan-Schreiber *et al.* [65]
USA	47 South East Asian refugee children Cross-sectional Child Depression Inventory	51 (depression)	Fox *et al.* [52]
USA	46 Khmer adolescents from high school Follow-up study over 12 years DICA, SADS, KSADS	PTSD/depression 50/48 (time 0) 35/14 (time 12 years)	Sack *et al.* [53]

TABLE 8.4 (*Continued*)

Country	Subjects and methods	Prevalence (%)	Reference
Gaza Strip	959 randomly selected school children Follow-up over 1 year Rutter Scale A2/B2 with PTSD cut-off score 9	PTSD (initial/1 year later) 26.8/20.9 (parent rating) 44/- (teacher rating)	Thabet and Vostanis [61, 62]
UK	30 refugee children and families Retrospective, case-controlled DSM-IV, Children's Global Assessment Scale	Psychosocial problems more than psychiatric problems	Howard and Hodes [54]

Though the prevalence rates vary widely across studies, the message that comes through clearly is that PTSD, depression and anxiety disorders form the bulk of psychiatric problems among refugees. The increased rates could be due to the multiple stresses that a refugee faces both at home and in refugee camps. Some critics have attributed this supposed higher rate of PTSD to application of culturally untested Western diagnostic systems and schedules. While this may be a valid criticism, it cannot be denied that a large number of refugees do manifest some symptoms akin to PTSD, although whether full-blown PTSD is present can be debated. Depression, anxiety disorders and somatic complaints are definitely more common among the refugee population. In spite of all these sufferings, studies have reported relatively well preserved social functioning among the refugee populations [30, 42, 43].

MANAGEMENT

The number of refugees has increased considerably in the last decades as millions of people have been forcibly displaced. To address the mental health needs of such large populations, specific management ability and approaches are required. The task becomes even more complex as the health and mental health infrastructure, if it ever existed, is destroyed and health professionals are eliminated [3].

The accumulation of traumatic experiences brings psychosocial dysfunctioning due to feelings of fear of mental illness, loss of trust, coping capacities and hope. However, it would still be incorrect to label an entire refugee group as suffering from mental disorders and requiring psychiatric help. As demonstrated by Mollica [67] (Figure 8.1), the percentage of the population actually suffering from any serious mental illness is very low.

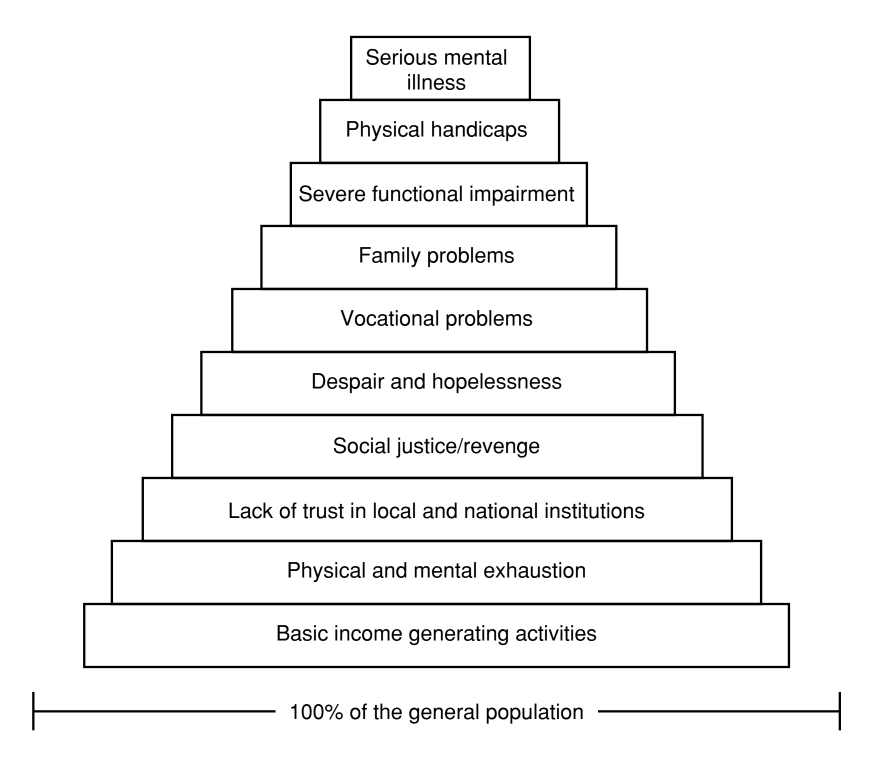


FIGURE 8.1 Trauma pyramid. Functional outcomes. Reproduced from Mollica [67] by permission of Richard F. Mollica

It is often seen that a number of international, governmental and non-governmental organizations come forward with their expertise in any refugee condition. But not all the help rendered is coordinated, focused or useful under the circumstances. Therefore, it becomes pertinent to develop a systematic course of management. Some guidelines are provided by the World Health Organization (WHO)/UNHCR manual *Mental Health of Refugees* [68] and the WHO's *Declaration of Cooperation. Mental Health of Refugees, Displaced and Other Populations Affected by Conflict and Post-Conflict Situations* [69]. Other instruments for assessment of mental health problems are being developed by the WHO. Some basic tenets that should be followed in meeting the mental health needs of refugees are that interventions should be integrated with overall health care; they should be responsive to all severity and kinds of problems; they should be part of the redevelopment of mental health services; and they should be sustainable, culturally sensitive, evidence-based and cost-effective. The following sections briefly describe some of the broad public health principles and strategies in mental

health care in complex emergencies. No attempt has been made to cover all the strategies that have been suggested or implemented.

Emergency Phase

In this phase, initial health needs and available resources should be rapidly assessed with the help and knowledge of local authorities. The aim should be to assess psychological problems, and the availability of economic resources and human resources. Assessments should be made keeping the culture of local community in mind.

Since most of the health requirements during the emergency phase are related to non-mental issues, the endeavour during this stage should be to make correct assessment of the situation and intervene immediately in cases of acute stress disorder due to physical or sexual trauma. Some of the common problems that require immediate intervention are fear and anxiety, sleep problems, reduced interest in work and self, and feelings of guilt, bereavement, anger. Many of these issues can be managed easily through community-based discussions of these issues and enumerating means to tackle them. Proper venting of emotions helps and a psychiatrist can help in catharsis, though it should be borne in mind that catharsis is not mandatory for all cases. The individuals should be taught to look for experiences of solidarity in their new environment. New coping skills should be taught. Mental health workers can also help by educating the community on issues of stigmatization, so that an already traumatized person is not overburdened with the problem of stigma. Towards this end, training of local mental health workers is required. Training should involve knowledge of psychosocial issues and mental disorders and basic management skills. On-the-job training could supplement existing knowledge. Important community leaders or focal persons or institutions can be introduced to simple ways of addressing the problems of refugees in an effective way. To overcome the traumatic experiences, some individuals may require individual or group interventions or occasionally administration of anxiolytics.

Mid-Phase

This phase starts after the initial few days or weeks of shock have passed and people have started the process of rebuilding. It is during this phase that the subject is likely to experience the frustrations and troubles of the life of a refugee in greater proportion. In addition, past memories may add to the problem, causing symptoms of PTSD and depression. Adjustment

problems, depression, anxiety, psychotic breakthroughs, behavioural problems and PTSD are common.

After a detailed assessment of the problem, a decision will have to be taken about the mode of management. Among refugees, community-based psychosocial interventions have been advocated. Interventions may include increasing community awareness; encouraging self-help groups and community care among the group; promoting human rights issues; giving individual, family and group psychotherapy; and provision of counselling sessions and activities for youth and children. A model multilevel approach to counselling and psychotherapy has been formulated by Bemak *et al*. [70], integrating traditional Western psychotherapy with indigenous healing methods, cultural empowerment and psychosocial education in a four-level intervention approach. However, wherever necessary, pharmacotherapy should be used. Inexpensive and locally available psychotropics should be used as far as possible, keeping in mind that some individuals may require medication for long periods. Those persons with pre-existing mental disorders should be prescribed psychotropics that had been effective previously, although the dosage may need to be adjusted.

While many psychosocial interventions have been suggested in the literature, it should be clearly recognized that there is no evidence of the effectiveness for most of them. Hence, counselling and psychotherapy for prevention or management of stress-induced disorders and associated disability should be advocated after careful consideration of the cost and any likely benefits.

Children may have some additional problems due to the loss of parents or other changes within home and family. Separation anxiety, reversal of roles, bed-wetting, phobic disorders, substance abuse and behavioural problems may be present in addition to depression, anxiety, PTSD and psychotic illnesses.

The family should be properly educated and informed about the symptoms of their children, the prognosis and the means of response. Community resources like mass media, schools or religious groups can be used to impart information. Library facilities and radio talk shows can be used to discuss the problems of children.

Children should be reintegrated into a family appropriately. Recreational and leisure activities in addition to basic amenities should be provided. Severe cases should be referred to specialized centres.

An outreaching, discreet and non-stigmatizing approach is essential for care and assistance to ex-detainees and victims of torture and sexual violence. Particularly in instances of rape, maintenance of absolute confidentiality is essential to protect against damaging cultural stigmas and to provide a trusting atmosphere in which adaptive change can be advocated. The aim of proper management should follow the basic tenets of respect, confidentiality, justice, and doing no harm [71].

Long-Term Management Phase

The long-term management should have two objectives: consolidation of the care provided initially and building of new resources.

In the consolidation stage, the focus should be on community-based approaches, and existing staff should be properly mobilized and trained, starting from local level to the national level. Ongoing training and supervision of the staff should be carried out. It is important to coordinate and supervise these activities, with one department of the local government or an international agency taking the lead. All the key governmental and non-governmental organizations should be involved and proper directions given according to the needs, keeping in mind the socio-cultural/political viewpoint. Family counselling; community dramas to relive previous traumatic experience and to discuss means of coping; cultural activities; sports; discussions on stigma, the problems of women and children, and human rights; and coping strategies are some of the activities that should be considered at this stage. Since the eventual aim is to build up the morale of the people and help them to rebuild their lives, all agencies, community leaders, traditional healers and religious organizations should be involved in the healing process. Self-help groups should be organized to look into the problems of specific subpopulations like widows, orphans, victims of rape and torture, ex-combatants, the elderly and victims of substance abuse. For special groups, psychotherapy in the form of family or group therapy should be carried out over a prolonged period. Local psychiatrists, general physicians, and psychiatric nurses should be trained in effective management of mental disorders and if necessary provided with basic kits of psychotropic drugs as advised by the WHO. If needed, camps should be organized to reach a greater population.

Last, but not least, the mental health issues of health workers should be taken care of. Issues of frustration, burnout, and hopelessness should be handled with empathy. Some of the important issues relating to management of mental health problems in complex emergencies are briefly described here.

Training. This should include training of primary health care personnel, supervision and on-the-job training whenever required, and monitoring and evaluation of trained personnel. Training should be a continuing process and should involve as many personnel as possible like doctors, nurses, primary health care personnel, teachers, religious leaders, community leaders, etc. However, a selection of training programmes is needed to optimize the benefits from the given resources. Training should cover the subjects' mental health problems, the social issues that precipitate psychiatric symptoms, stigmatization, human rights issues, management, and means of

developing new set-ups to tackle the current problem and also future problems.

Mental health education. Knowledge about mental health problems should be incorporated at all levels of schooling. Discussions of relevant issues at school should be encouraged, so that children and adolescents have a platform to discuss issues related specifically to their lives. Younger children could be taught through plays or stories. Older children could be taught through special discussions, films, and reading material. A school counsellor may be of a great help in some cases.

Emergency services. Emergency services should be established with the support of available organizations and staff adequately trained to handle future problems. Mobile teams should be formed. Initial technical assistance, including material and financial support, will have to be provided.

Self-help groups. Self-help groups from among the local populations should be encouraged and their activities supported initially to ensure that they work effectively. These groups can be extremely effective in providing mutual support, which is a crucial ingredient for better mental health.

Supply of psychotropics. For countries that lack basic psychotropics, international organizations and other governments can assist in providing supplies, until the national government is able to. Financial institutions may have to step in at times to provide assistance in the development of proper infrastructure.

Community care facilities. Mental health workers should ensure that mental health facilities are integrated into community care and that different psychosocial interventions at a community-based level are available. Outreach facilities should be developed. The staff should be properly trained to tackle the specific needs, not only of refugees, but also of the general population.

Increasing awareness. Often the awareness of mental health issues, per se, is so poor in some regions that it becomes difficult to organize resources directed towards mental health at times of crises. Steps should be taken to increase the awareness of mental health issues through mass education campaigns using newspapers, television, newsreels, brochures, group discussions, etc.

Technical support. In countries lacking an initial set-up, technical support needs to be provided until minimum facilities are created. It is imperative

that the efforts to provide technical assistance are coordinated so that the institutions best suited are involved in an orderly fashion.

Monitoring systems. A sustainable monitoring system should be set up. It should be simple and cost-effective. Data collection tools should be user-friendly. Networks should be set up, if necessary, or some system created to send collected data to centres having sophisticated data-processing units.

Inter-agency and inter-governmental coordination. The problems of refugees and internally displaced persons are so overwhelming that it is not possible for one organization to manage them. Often refugees become an issue not only for one country but for many, as was seen in some recent conflicts. Cooperation among the various agencies, organizations and governments is required to facilitate smooth coordination of the process of rehabilitation. Political and financial issues should be clarified and the need of mental health defined clearly.

Research. Research is the key to providing answers to fundamental questions in this area. It is important to emphasize that all research must conform to rigorous ethical standards. Some of the important areas for further research include the following:

1. A more clear and valid distinction between mental health symptoms and disorders among refugees.
2. Magnitude and determinants of mental disorders in these populations.
3. Medium and large team outcomes of mental disorders among refugees.
4. Effective and sustainable models of mental health care among these populations.
5. Effectiveness and cost-effectiveness of interventions, especially during the early phase after stress for the prevention of chronicity and disability.
6. Interface and integration of mental health care with overall health care.

INTERNATIONAL ORGANIZATIONS

A number of international agencies operate during crises involving refugees or IDPs. Each performs separate or at times overlapping functions. Within the UN system, the Inter-Agency Standing Committee, chaired by the Emergency Relief Coordinator, is responsible for the smooth functioning of relief efforts.

Today's humanitarian emergencies are both multidimensional and complex, and many other actors—such as governments, non-governmental

organizations, UN agencies and individuals—seek to respond simultaneously. It becomes essential that all efforts are well coordinated and the Office for the Coordination of Humanitarian Affairs (OCHA) plays a major role in coordination.

There are three major ways in which OCHA fulfils its role. First, it coordinates the international humanitarian response, including contingency planning when appropriate. It consults UN country teams and different UN organizations, makes an initial assessment of needs and conducts interagency consultations at the headquarters to designate the roles to be played by each organization. It also mobilizes resources and sends out international appeals for aid and relief supplies. Second, it provides the humanitarian community with support in policy development by ensuring that major humanitarian issues are addressed, including those that fall between the existing mandates of the organizations. Third, it speaks on humanitarian issues, giving voice to the silent victims, and ensures that their concerns are reflected in the humanitarian efforts, and to that goal it uses the electronic media. Between 1992 and 1998, OCHA coordinated efforts in 27 countries across the world and responded to 468 disasters.

Other international agencies involved in providing assistance for the mental health needs of refugees and IDPs include the UNHCR, the High Commissioner for Human Rights (OHCHR), the United Nations Development Programme (UNDP), the WHO, the International Federation of the Red Cross and Red Crescent Societies (the Federation), and the United Nations Children's Fund (UNICEF).

The main role of the WHO is to support the national authorities in strengthening health services and in improving health care for all segments of the population, including special groups. The WHO, through its normative and field activities and in cooperation with concerned ministries, other international agencies, collaborating centres, and academic and research institutions, works towards better management of resources [3]. Through its Emergency and Humanitarian Action (EHA) agency, the WHO functions at disaster sites. Other units, including the Mental Health and Substance Dependence Department, cooperate with the EHA in their efforts.

The specific roles of the WHO in mental health are as follows:

- collection of systematic information on the extent, type and severity of the mental health problem
- providing assessment instruments, guidelines and other technical material
- suggesting minimal standard of care
- integrating mental health with other health intervention
- integrating emergency care into development of sustainable health systems and services

- monitoring and evaluation of programmes
- compiling an evidence base for effectiveness of interventions
- providing high-level advocacy of the mental health needs of the affected populations
- integrating the responses of non-governmental organizations
- working in coordination with other UN agencies.

In recent years, the WHO has been active in a number of conflict-affected regions of the world and has been helping with the mental health problems of the refugees and IDPs along with other health issues.

CONCLUSIONS

There is an urgent need to examine the evidence base for all public health and humanitarian interventions by health professionals and health agencies [72]. This is even more needed for mental health interventions during and following conflicts, which have often relied more on faith and convictions than on evidence. As a summary, the following issues are pertinent to the area of mental health of refugees.

1. A significant proportion of refugees and IDPs suffer from mental disorders and mental/behavioural problems. However, a clear distinction between disorders and problems must be made. Disorders are more clearly defined by characteristic symptoms and signs, generally cause significant disability, and are often longer lasting, while problems may be in the form of psychological distress, without the specificity of disorders. Mental health services should be able to contribute to the care of both the disorders and problems. But the distinction should always be kept in mind, since the interventions that are effective for disorders may not necessarily work for the problems, and vice versa.
2. The specificity of some traumatic disorders as an exclusive or even predominant manifestation of stress among refugees has not been demonstrated, and hence should not be the basis for planning services. The concept of PTSD should not be the benchmark for judging the severity of stress or need for services. PTSD should also not be the central public health argument for the mental health needs of populations affected by severe stress.
3. Mental health services are necessary for conflict-affected areas, but the need is for developing or redeveloping the general mental health services that are useful for the whole population, and not only special groups. Even if one accepts the argument that there are some disorders that are specific to populations affected by conflict, these can be well

looked after by an efficient general mental health service. Special services for "trauma victims" also disregard the needs of substantial numbers of individuals who were suffering from disorders prior to the conflict. A case can perhaps be made for special mental health services in areas where a previous health system did not exist, like refugee camps. But even here, mental health care should be organized as a part of the overall health care for it to be maximally effective.

4. A clear distinction should be made between interventions that are to prevent and treat mental disorders and others that are to enhance the civil participation of refugees. The former should be chosen according to the available scientific evidence for their effectiveness. The latter could also enhance mental health; however, the evidence for this is extremely unclear. Hence these should not be implemented as "mental health interventions", although in their own right these welfare and participatory interventions may be desirable and beneficial.
5. A clear body of research is needed on the magnitude and types of mental health disorders, their course, the associated disability and the cost-effectiveness of relevant interventions. The use of internationally recognized tools and methods, like diagnostic criteria for disorders and outcome measures, is necessary for making the results of the research acceptable as evidence for programme planning.

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CHAPTER

9

The Homeless Mentally Ill

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INTRODUCTION

High rates of severe mental illness among homeless populations have been consistently reported in the literature, first in North America and Australia [1–4], and then in Europe, where studies show similar results [5–7] despite differences in health care systems and social benefits. In all these studies, the prevalence of severe mental disorders is uniformly reported to be four to five times higher than in the general population [8, 9].

The process of de-institutionalisation and the shortage of cheap accommodation have been held responsible for the homelessness of the mentally ill [10–12], especially in the USA, along with the failure of the health system to prevent homelessness after people have been hospitalised [13]. For Sullivan *et al*. [14]:

> The emergence of a substantial homeless population over the past twenty years can probably be best understood as resulting from a combination of structural changes (e.g., declines in low-cost housing stock, reductions in entitlements, and growing numbers of persons in poverty) and individual vulnerabilities (e.g., mental illness, substance abuse). That is, over the past twenty years, structural factors have produced an imbalance between available low-income housing units and the demand for them, setting the stage for homelessness. In this context personal vulnerabilities determine who, within this context of housing scarcity, becomes homeless. This could be the reason why persons with mental illness are over-represented among the homeless relative to the general population, since mental illness is most likely one of many vulnerabilities that confer risk for homelessness.

Odell and Commander [15] argue that the separation of the mentally ill from the remainder of the homeless population is ill-founded. They point to non-clinical factors that the severely mentally ill homeless share with their non-mentally-ill counterparts and propose, rather than seeking solutions in

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improved mental health service delivery, to stress the need for generic measures to tackle the problem of homelessness.

Most of the authors accept the idea that the homelessness of the mentally ill arises from structural features in the present society, such as high unemployment, restricted social security benefits, family disruption and reduced availability of affordable housing. However, some authors believe that this excess of severely mentally ill homeless people should call into question the adequacy of implementation of community care in an era that has seen a dramatic decrease in psychiatric hospital beds [15]. Consequently, people with severe mental illness have been rendered especially vulnerable to these adverse societal conditions as a result of their clinical status and a lack of appropriate psychiatric services [16].

The homelessness of the mentally ill results not only from factors such as individual vulnerabilities, and lack of cheap housing and appropriate psychiatric care, but also from other factors, such as the tendency to put deviant people in jail without taking into account possible mental disorders. Indeed, the relationships between mental illness, homelessness and criminality have been extensively studied: first, criminality is more frequent among the homeless than in the domiciled population; second, criminality is more frequent among the mentally ill homeless than among the homeless without mental illness and domiciled patients suffering from mental illness; third, there are more psychiatric problems in the homeless who have been in jail than in the domiciled. All this means that among the homeless there are an excessive number of mentally ill people who commit crimes [9]. Some have argued that this is due to bias in prosecuting the mentally ill. However, it seems that these prosecutions concern not minor offences but serious violent crimes, suggesting some genuine interaction between homelessness, mental illness and violence.

This chapter will review some key studies which aim to shed light on these issues and discuss some of the methodological problems in studying homeless mentally ill populations.

DEFINITIONS OF HOMELESSNESS

Homelessness is not consistently defined [10], and this absence of consensus makes comparisons difficult in terms both of the actual number of homeless persons and of morbidity. In their Chicago study, Rossi *et al*. [17] defined as homeless a person who lives in a shelter or who does not own or rent a place in a conventional setting. In Los Angeles, Farr *et al*. [18] introduced a time limit of 30 days: people are homeless if they live in a shelter or have not rented a home in a conventional setting during the last 30 days. In Ohio, Roth *et al*. [19] extended the definition beyond shelters and rough sleeping

places to a cheap hotel or motel if duration does not exceed 45 days. Finally, Dennis [20] proposed the inclusion of all aspects of the continuum from those who sleep outdoors to those who live in any precarious, impermanent setting, on the grounds that many people change status from time to time.

This last definition was adopted by the French National Institute of Demography (INED) in a census study, which considered a homeless person to be someone who had no place to sleep, and consequently had either to look for a place in a night shelter, on the street, or in some other place inappropriate for sleeping, or with family or friends on a non-permanent basis.

SAMPLING PROCEDURES IN RESEARCH ON HOMELESS PEOPLE

The sampling procedures in research on homeless people are essential and very complex. The homeless population is by definition unstable. People become homeless and stop being homeless by intermediate stages. In addition, homeless facilities have diverse admission policies and many of them are selective: some facilities require documents, admitting only people having a legal status; others do not accept those who are drunk or under the influence of drugs. Some facilities accommodate women only; others, only young people. Fournier [9] has shown in Montreal how much psychiatric morbidity varies across facilities for the homeless. Consequently, differences in the reported prevalence of mental disorders may be due to a biased selection of facilities; therefore, the sampling procedure should be carefully defined. The demographic composition of samples, especially sex ratio and age limits, has to be considered when comparing data, since morbidity is very much linked to these; homeless populations are generally mostly male and young.

According to Burt [21], sampling methods can be classified into three generations. The first generation relied on experts' opinions, as in the case of data from the Community for Creative Non-Violence (1983) or the US Department of Housing and Urban Development (1984) (quoted in Burt [21]). Then came a second generation in which surveys were conducted at night simultaneously in streets and shelters, as in the Nashville Coalition or the Chicago studies (quoted in Burt [21]) This method, which was tried by the US Census Bureau in 1990, is difficult to implement, because night street samples are very hard to gather.

Researchers then proposed a third generation method based on service user samples only. This sampling lasts longer and is done in the daytime [21–23]. It requires accurate canvassing of a given facility and a system able to assess diverse levels of utilisation. In addition, this method assumes that

homeless service users represent homeless people as a whole; in fact, 85% of homeless people interviewed at night in the streets of Los Angeles admitted to having slept in a shelter during the past month [22].

The Course of Homelessness (COH) Project, a longitudinal study of predictors of exit from and re-entry into homelessness (1563 adults were interviewed between October 1990 and September 1991), used a mixed methodology. In order to represent the homeless populations of two Los Angeles County communities—the urban downtown area (which has the largest and most dense concentration of homeless individuals in the county) and the suburban west side beach communities of Santa Monica and Venice (which contain the second highest concentration of homeless)—Burnam and Koegel [22] used a multi-stage stratified probability sample design. Within each of the two communities, they designed three mutually exclusive sampling strata: the population that used emergency shelter beds, the homeless population that used meal facilities (for example, soup kitchens) but not shelter beds, and the homeless population that used neither shelter nor meal services. To sample homeless individuals who did not use shelter or meal facilities, they drew a sample of census blocks in each of the areas (weighted proportionally to the likelihood that homeless individuals would be found in the block at night). These blocks were searched during late night and early morning hours. Individuals found in the blocks were screened, and those who were homeless and had not used shelter or meal facilities in the past month were selected to participate in the survey. Across the two communities, they proportionally allocated interviews to the estimated homeless population size.

This sampling design combined elements of two approaches (the service setting approach and the one-night ''blitz'' approach), and the design was conceived in order to allow estimation of the probability of sampling each individual. Probabilities were estimated with two different underlying stochastic models that were conceived as bounds on actual probabilities, one assuming that individuals repeatedly go to the same facilities and street location over time, and the other assuming that individuals choose randomly among geographically available facilities and street locations. Estimation of probabilities under each of these models included two components: the selection of facilities and street locations on any given day (or night) of sampling, and the selection of individuals within locations. In the analyses, data were weighted by the reciprocal of the estimated probability of selection, using the average of the estimates derived from the two stochastic models.

In our study in the city of Paris [7], we followed the service user sample method and added a small street sample to check their use of facilities. A sample of 1416 people was collected with the assistance of INED by means of the following steps: (a) exhaustive listing of available facilities

(night shelters, food kitchens); (b) classification by size of facility and, for food kitchens, weighting for number of days and of times per day the facility was open; (c) randomisation of blocks of six interviews per facility; (d) a second randomisation in order to interview ''randomised'' people within the facility.

Consequently, homeless persons were recruited from different types of night shelter (owned by the city or by religious and other charities), and from places where free food was given. In addition, we conducted 43 interviews during the night with people found sleeping in the street. The final sample contained 838 subjects; the mean response rate was 64.2% (71.2% in shelters and 58.6% at the food kitchens). This sample was weighted in order to take into account those who had used more than one type of facility at the same time; for instance, eating at one of the food facilities and spending the night in one of the shelters (27.0% of the subjects were in that situation, and the final weighted sample contained 715 subjects).

These examples illustrate the complexity of sampling designs in research on homeless populations. In addition, the nature and composition of the homeless population may change tremendously with new immigrant populations, such as East European immigrants in Western Europe. This implies that a survey done at one point of time needs to be replicated quite often to be accurate.

DEFINITION OF CASES AND ASSESSMENT INSTRUMENTS

Most of the studies of homeless populations used standardized diagnostic interviews for selected diagnoses because an exhaustive interview lasts too long for these populations. The most widely used instruments were first the Diagnostic Interview Schedule (DIS [24]), and then the Composite International Diagnostic Interview (CIDI [25]). Odell and Commander [15] used a clinical standardized interview and medical records; Gill *et al*. [6] used the Schedules for Clinical Assessments in Neuropsychiatry (SCAN [26]), preceded by screening questions on psychoses in a two-step procedure. In an Australian study [3], psychoses were detected by a screening questionnaire, and individuals rated positively were referred to a psychiatrist for a clinical interview.

Psychoses are assessed in almost all studies. Substance-related disorders are also systematically assessed. Personality and cognitive disorders are often included. For specific comparisons, researchers can select some subtypes of disorders. For example, in the study by Sullivan *et al*. [14], the definition of mental illness included lifetime schizophrenia (excluding

patients without any symptoms in the past 3 years) and lifetime affective disorder (excluding patients whose episode fell below DIS severity criteria—e.g., those who did not see a doctor, did not take medication, did not experience a deterioration in functioning and were not hospitalized—as well as those who had a single episode only, those who had no episode in the last 3 years, and those with grief or dysthymia). This definition was used to focus on persons with the most chronic and serious mental disorders.

PREVALENCE OF MENTAL DISORDERS AMONG HOMELESS PEOPLE

In most studies of homeless populations, the lifetime prevalence of mental disorders is 28–37%: 3.3–5% for severe cognitive disorders (dementia), 7.8–13% for schizophrenia, 8.2–17.5% for severe depressive disorders, and 5% for bipolar disorder. In addition, a pooled lifetime prevalence estimate from diverse studies indicates that 56% of homeless people in their lifetime will meet criteria for a substance-related disorder [30].

In Table 9.1, North American and Australian data [2–4] are compared with European data from studies conducted in France [7], Spain [27], Germany [5] and the UK [6]. Our Parisian rates were higher than those reported in the USA and Australia, except for substance-related disorders. The rates were, however, closer to those reported in the other European studies.

Table 9.1 One year prevalence of mental disorders among homeless in different countries (%)

	USA [Koegel *et al.*, 2; Fischer *et al.*, 4; Fischer, 8] Australia [Herrman *et al.*, 3; Hall *et al.*, 28]	UK [Gill *et al.*, 6]	France [Kovess *et al.*, 7]	Spain [Vasquez *et al.*, 27]	Germany [Fichter *et al.*, 5]
Cognitive disorders	3–3.5		10.1	6	8.9
Psychotic disorders	7.8–13		5.8	6	9.6
Bipolar disorders	5		1		
Depressive disorders	8.2–17.2		23.7	18	24
Alcohol-related disorders	35–41	31	14.9	26	74
Drug-related disorders	USA: 10 Australia: 34		10.3		

Major differences concerned alcohol-related disorders, which had a point prevalence of 26% in the Spanish study, 31% in the UK study and 74% in the German study. In the Australian study, 35% of the homeless had alcohol dependence in the past 12 months and 41% had an alcohol-related disorder; this rate is very close to the Los Angeles prevalence rate (40%). The German study was conducted in 1989/90, and appears to have covered a peculiar population: males only, middle-aged (only 1.4% were under 25), and mainly living in the street. Only 20% of this population was in shelter and the mean duration of homelessness was 9 years. These factors may explain the higher prevalence of alcohol disorders.

Homeless people in Sydney were 3.4 times more likely to have a substance-related disorder than those in Los Angeles. This difference is striking, given the similar rates of substance-related disorders among the adult population in Australia (4.0%) and the USA (3.6%) [28, 29]. It appears that the substance of choice among the homeless in Munich was alcohol, whereas fewer were dependent on alcohol in Sydney, where there was a greater level of dependence on illicit drugs, especially heroin. In the Australian sample, 51% of persons with substance-related disorders also had at least one other mental disorder.

In our Parisian study, one schizophrenic out of three had an alcohol-related disorder and one out of five had a drug-related disorder. Alcohol abuse was also present in one-third of those with depressive disorders. The prevalence of most mental disorders did not vary with place of residence, place of birth, or indeed any of the socio-demographic variables that were measured. However, alcohol-related disorders were more frequent among men than women (odds ratio 3.6), and in those with low educational status; they were very rarely found in residents of long-term shelters, but very often in street people (35.4%). In addition, alcohol-related disorders are the only ones for which place of birth increases the risk; it is increased 1.55 times if the subject was born in France. Drug-related problems were also linked to social variables, being more frequent in young people (34% of those under 25 years) and in men (odds ratio 2.3).

THE USE OF HEALTH CARE SERVICES BY THE HOMELESS MENTALLY ILL

According to a recent review of North American studies [9], 25–40% of homeless people have been hospitalized in a psychiatric ward at some time in their life. Despite these high figures, most authors maintain that health services are underused by the homeless. According to Lomas and Honnard [30], vagrant mentally ill patients avoid psychiatric hospitalization, and outpatient psychiatric facilities are rarely visited by these patients.

Drake and Adler [31] report that the homeless often refuse any type of medicine or psychotherapy, even the offer of low-cost available housing.

A review by North and Smith [32] reveals that the rates of utilisation of mental health care facilities by the homeless are very high compared with those of the general population. Yet, during a more recent period, their rates have been falling significantly, a fact which may mean that they are losing all connections with these facilities.

Appleby and Desai [13] found that the number of homeless among people hospitalized in psychiatric wards has greatly increased during the last decade. However, they report that the homeless are more likely to be refused admission than the housed people, that 20% leave the hospital before being discharged and that few are kept in long-term wards.

Several authors maintain that homeless mental patients fear being hospitalized again, and that they prefer to live in the street, which offers them freedom, anonymity and the interpersonal distance they wish. Having medical insurance or not does not seem to be a relevant factor. Kalifon [33], in research carried out with the hospitalized homeless, notes that 62.5% of such patients deny their mental health problem and are either looking for shelter or trying to escape a difficult situation. For the rest (37.8%), hospitalization and housing problems are accepted as a result of illness, and they ask for treatment once in hospital. The authors conclude that many of the homeless consider hospital to be a place to sleep, eat, meet other people, and to be a dispatching service to other programmes or services. This attitude produces negative reactions from the staff, who at best feel awkward and at worst imposed upon.

In the Parisian survey, a first set of questions concerned the presence of severe physical problem or handicap: 25.9% of the subjects reported a problem of this nature, 16.7% said they needed some form of medical treatment, and 14.1% said they took treatment regularly; 53.6% declared that they had received care in the last 6 months, and 13.8% reported that they had been hospitalized (55.1% answered positively to one or other of these questions). These percentages were higher for those reporting a severe disease or a handicap: 75.7% overall. Of the homeless, 42% declared that they had been treated for psychiatric symptoms: among those who had a psychiatric diagnosis during the preceding year, the rate was 59.3%, with a higher rate for women than men. Thus, it appears that homeless people suffering from mental disorders were using the health system less frequently than those suffering from physical disease.

In order to clarify which factors predict care for mental disorders, two series of logistic regression were computed, using ''any contact with the health system for psychiatric symptoms'' and ''hospitalization'' as dependent variables. Men were less frequently in contact with the health system than women, especially in the case of depressive disorder. Young homeless

subjects under 25 years old appeared to be undertreated: they had six times less contact with the health care system in the case of schizophrenia and alcohol- or drug-related disorders, and four times less in the case of depressive disorder.

Suicide attempts were an important factor in being in contact with the system: for people with schizophrenia, it multiplied the number of contacts by 20; for people with alcohol problems, by 5; and for drug addicts, by 6.6. The presence of a concomitant physical disease increased contacts for psychiatric symptoms: it multiplied the number of contacts by 4 in the case of alcohol-related disorders, and hospitalization was multiplied by 3.7 for homeless people with schizophrenia.

Concomitant alcohol- and drug-related problems increased levels of contact in the case of depressive disorders. Being born in France increased contact with the health system for alcohol-related disorders, and having had a job increased the likelihood of contact for drug-related disorders, irrespective of age. Negative life events before the age of 12 increased the chance of hospitalization for depressive disorders.

The type of contact varied according to the problem: homeless subjects suffering from schizophrenia and delusional disorders were those most frequently hospitalized (39%) and prescribed psychotropic drugs (68.3%). People suffering from drug-related disorders were also very much in contact with the health system. They reported contact with physicians and psychiatrists and were hospitalized nearly as often as people with schizophrenia. Those suffering from depressive disorders had the least contact: 52% had seen a physician and 40% had been given psychotropic drugs.

The location of the contact was analyzed in terms of the type of mental disorder and the place of residence. Those living in long-term shelters had access to a general practitioner relatively often (29%), while people in short-term shelters or living in the street rarely had access to primary care (7.8% and 6.3%, respectively); the same observation applies to specialist and nurse contacts at shelters. In contrast, short-term shelter users and street people used charity clinics more often (9.5% and 7.3% versus 1.1%). Short-term shelter users and street people stated that they had spent a night in hospital or in the police station more often than did those in long-term shelters. The percentage of street people who had spent a night in hospital in the preceding year was 40.6%. General resources available to the homeless were used quite frequently: during the preceding 2 weeks, short-term shelter users and street people had used free clinics, washing facilities or transportation. Half of them had met a social worker from the various agencies, 64% of which were run by the city of Paris.

Generally, those suffering from schizophrenia and delusional disorders and those suffering from drug-related problems were more often in contact

with health care than the remainder. Among those suffering from schizophrenia, 9.6% were receiving care in free public clinics (run by the public sector system) and 16.8% in outpatient clinics, more than all other groups. By contrast, those suffering from depressive disorders and alcohol- or drug-related disorders were more frequently cared for at hospital casualty departments and hospitalised. They also had the least frequent contact with general practitioners. When asked about contact in the two preceding weeks, homeless subjects with schizophrenia reported the most frequent use of free clinics (30%). As expected, drug addicts had more frequently been in jail (12.6%) and at police stations (38.4%). However, 20% of homeless subjects with schizophrenia had also spent a night at a police station.

Overall, more than half of our homeless sample stated they had been treated over the preceding 6 months. Ten per cent were treated by a general practitioner, but this percentage differed according to the place where they lived (29% for those in long-term shelters, 8% for those in short-term shelters and 6% for those living in the street). The use of hospital facilities, whether outpatient clinics or hospital emergency departments, was most common (9.5%), and this proportion was the same wherever our respondents lived. Charity clinics were mostly used by people in short-term shelters and street people, and clinics associated with the shelter by those living in long-term shelter.

During the preceding year, 30% reported they had spent at least one night at hospital, with this percentage rising to 40% for street people. It can be added that 20% of the people in this last category had spent a night at a police station, and overall 4% had been in jail during the same period.

In this study, homeless subjects suffering from mental disorders during the survey period had surprisingly good access to care: those suffering from schizophrenia had treatment in 70% of cases; 39% had been hospitalized, 68% had received psychotropic drugs, and 41% had seen a psychiatrist. Interestingly, drug addicts had the highest access to care (77%), and their contacts followed the same pattern as that for people with schizophrenia. Only half of those suffering from depressive disorders had been treated, mainly by general practitioners, and 25% had been hospitalized; people with alcohol-related problems had been treated in 65% of the cases, with a 37% hospitalization rate. This could be due to a smooth de-institutionalization process in France and to a shift of resources from full-time hospitalization to outpatient resources and housing alternatives.

However, these relatively high levels of contact do not mean that care is adequate, and our data underline the number of patients who leave hospital without residential placement. Moreover, having contact with the health system does not guarantee adequate follow-up, and there are complaints from many sources that this is a real problem. Young homeless people are a

problematic group, having six times the risk of not being in care in the case of schizophrenia and drug abuse, five times more for alcohol-related disorders and four times more for depressive disorders.

For homeless subjects suffering from mental disorders, it appears that contact with the health system occurs particularly when there is an additional problem: a suicide attempt, physical disease or alcohol/drug-related problems. This is not what would be expected if this population were treated according to the ''sectorization'' philosophy of care, which emphasizes continuity of care and social intervention.

International comparisons of use of the health system are extremely difficult, because each research group uses its own methods and definitions. We did not compare our results with the Spanish data [27] because that study did not provide this particular information. The German study [5] used the lifetime hospitalization rate for mental disorders as a measure of care, obtaining 34.5% in general hospitals and 27.6% in psychiatric hospitals. These rates are double ours (13.1% and 10%). Data from the UK [6] show lower rates of hospitalization for mental disorders (15%) and lower use of psychotropic drugs (32% versus 42.4% for depressive disorders). The St Louis study [32] allows a better comparison: except for bipolar disorder, our hospitalization rates are higher, and rates for overall instances of care are twice as high for schizophrenia and depressive disorders and three times higher for substance-related disorders. These comparisons are approximate, but it seems that patterns of care for homeless people follow the same tendency in the various countries concerning hospitalization for mental disorders. There was too little information to draw conclusions about outpatient care, although this is probably more problematic.

RISK FACTORS FOR HOMELESSNESS IN THE MENTALLY ILL

According to Odell and Commander [15], research into the antecedents of homelessness among people with severe mental illness has been limited. Most work has been carried out in the USA, and has failed to establish the chronological relationship between hypothesized risk factors and the onset of homelessness [34]. The only risk factors identified as predating homelessness are childhood adversity, problem behaviours and substance-related disorders [35, 36], although the pathways by which these might contribute to homelessness remain unclear. In a case control study carried out in the UK [36], individuals who had been homeless were compared with others who had never been homeless. Cases and controls were sampled from those in contact with psychiatric services, a feature which was acknowledged by the authors as a potential source of bias. Cases were identified through a

dedicated mental health service for homeless people [37], and controls were sampled from an inner-city community mental health service.

For many homeless respondents, problems were evident in childhood when family living situations broke down and they were placed in care. However, the absence of childhood factors in the multivariate model indicates for the authors that their impact on homelessness is likely to be mediated through ensuing social difficulties and, in particular, a lack of ongoing support into adulthood. Unlike achievements in education and employment (which were uniform across cases and controls), social support appeared to be a key factor in preventing homelessness. Increased isolation from childhood carers was apparent among subjects prior to the onset of homelessness. In contrast, many of the control group continued to live with family members or, having been born locally, had family nearby. Families may provide considerable support to vulnerable people in terms of basic assistance and companionship, as well as help at times of crisis. People without such support may be severely disadvantaged and have additional needs that must be anticipated if homelessness is to be averted.

A substantial number of homeless people, as opposed to only a few controls, had behavioural problems in childhood. The authors stated that, although a complex relationship between childhood behaviour and a predisposition to homeless is conceivable (for example, through compromising childhood placements and subsequent support), there may also be a direct link, with antisocial behaviour persisting into adulthood [38]. Since many subjects reported extensive criminal records as well as experiences of both alcohol- and drug-related problems, it was only the latter that persisted in their multivariate model. Substance abuse acts in a variety of ways to increase the risk of becoming homeless, diverting money from housing and other daily living expenses, as well as leading to a loss of social support and contributing to criminal behaviour [39]. The latter in turn may jeopardize housing by causing conflict with family and landlords, or by leading to imprisonment. The authors add that coexistence of mental health and substance-related problems may paradoxically result in reduced support from psychiatric services, as many mental health and substance abuse services operate separately without adequate coordination between them [40]. In addition, the range of available housing options may be severely restricted by entrance criteria excluding those with substance-related problems (and criminal records), particularly from shared or sheltered housing [16].

In this study, in one-third of homeless respondents, the onset of psychosis followed the first episode of homelessness, indicating that mental illness was not a contributory factor. Furthermore, contrary to a popular perception that homelessness may be linked to poor treatment compliance, most of those whose illness began prior to becoming homeless had established and

maintained contact with psychiatric services. Where there was evidence of comorbidity, substance abuse and behavioural disturbance appeared to be antecedent to both homelessness and the onset of psychosis in most cases. For the authors, these findings suggest a limit to the extent to which psychiatric services may be able to prevent homelessness among people with severe mental illness.

Substance abuse and the absence of family support are key factors contributing to homelessness among people with psychotic disorders. This suggests that further services for people with comorbid psychotic and substance abuse disorders, including residential provision, are required. Additional interventions should also target patients with adverse childhood experiences and poor ongoing support. While not discounting the mental health care needs of homeless people with psychotic disorders, this aspect has arguably been overemphasized, while the similarities between homeless people who are mentally ill and their non-mentally-ill counterparts deserve greater attention [41]. An integrated approach in which mental health services complement and support other agencies tackling homelessness is necessary.

PATHWAYS TO HOMELESSNESS FOR THE MENTALLY ILL

Sullivan *et al*. [14] explored pathways to homelessness for mentally ill persons by examining mental illness as a risk factor for homelessness as distinct from other personal vulnerabilities (such as histories of poverty, abuse, or family instability) that are likely to increase the risk of homelessness when affordable housing is in short supply. Since a longitudinal study of a community sample over many years, with repeated assessments of all potential risk factors including mental illness, would be prohibitively expensive, they used data from two existing data sets: the COH project (described in Sullivan *et al*. [14]) and the National Epidemiological Catchment Area (ECA) Survey [29]. To examine pathways to homelessness, they conducted three analyses. First, they compared and contrasted three groups: the mentally ill homeless, the non-mentally-ill homeless (obtained from the COH study), and the mentally ill housed (obtained from the ECA study). The ECA survey, conducted in five sites across the USA between 1980 and 1984, was designed to estimate the prevalence of mental disorders in both treated and non-treated community populations. Data from the Los Angeles ECA site of the non-institutionalized ($n = 2901$) were used.

The comparisons revealed that the mentally ill homeless are more demographically similar to the non-mentally-ill homeless than they are to mentally ill housed persons. Current alcohol and drug dependence follow a

similar pattern. Like the non-mentally-ill homeless, the mentally ill homeless are at very high risk of substance abuse. Homeless subjects have almost twice the prevalence of alcohol dependence and six times the prevalence of drug abuse of housed subjects. These comparisons show that homeless persons, whether or not they are mentally ill, are more likely to be socially disadvantaged (less educated, ethnic minorities) and to have a high likelihood to be currently dependent on alcohol or drugs.

Homeless persons appear to have experienced considerable poverty in childhood. About one in five stated that their family was on welfare and that their primary caregiver was never or rarely employed. The mentally ill homeless did not differ significantly from the non-mentally-ill homeless in terms of childhood poverty. However, the mentally ill homeless did experience significantly more family and home instability. Of the mentally ill homeless sample, 60% had a primary caregiver who was either mentally ill or physically disabled, and more than one out of four were placed at least once in an institution or foster care. Furthermore, mentally ill homeless persons were also more likely to come from backgrounds marked by physical or sexual abuse. Compared with the non-mentally-ill homeless, twice as many mentally ill homeless (almost 40% of the sample) reported having lived in a household where violence or abuse took place regularly. One-third had actually been physically abused, while 5% reported having been sexually abused. Both physical abuse (19% vs. 13%) and sexual abuse (12% vs. 1%) were more frequent in women. By logistic regression, five factors uniquely associated with being mentally ill were identified: having been physically abused ($OR = 2.88$; $P < 0.0001$), being white ($OR = 1.78$; $P < 0.0001$), residential instability in childhood ($OR = 1.60$; $P = 0.005$), caregiver illness ($OR = 1.39$; $P = 0.02$), and having some college education ($OR = 1.38$; $P = 0.02$).

The authors stated that the relationship between homelessness and mental illness is rather complex. In some ways the mentally ill homeless appear to be more privileged (better educated, less likely to be of minority ethnicity) than other homeless persons. On the other hand, they share with other homeless people backgrounds marked by poverty: dependency on welfare, childhood hunger and family unemployment. The mentally ill homeless appear to have more in common with other homeless people than they do with the mentally ill housed population. Furthermore, homelessness appears to be a phenomenon rooted in the impoverished and disadvantaged backgrounds of homeless people regardless of their subsequent mental health status.

However, the mentally ill homeless are distinct in terms of childhood risk factors. They have significantly higher scores on every indicator of childhood family instability and violence or abuse. About one-fourth of the mentally ill homeless experienced residential instability with their family

as a child, about one-fourth were placed out of their homes, and more than one-third either witnessed violence within the household or personally experienced abuse. The authors conclude that the mentally ill homeless have received a ''double dose'' of disadvantage— poverty with the addition of childhood family instability and violence.

Sullivan *et al*.'s analyses [14] do not support the notion that mental illness represents a distinctive pathway to homelessness, but rather that the relationship between mental illness and homelessness is both complex and dynamic. While programmes that attempt to improve the symptoms and functioning of homeless adults and to alleviate the chronic stresses of homelessness certainly help some individuals, they fail to address the deeper origins of homelessness, arising from both the structural and personal vulnerabilities that exist for all homeless people. For the subpopulation of seriously mentally ill adults, effective interventions to prevent or treat substance abuse appear to be important in reducing the risk of homelessness. Consequently, programmes designed to help the adult mentally ill homeless should be coupled with programmes that address childhood risk factors for homelessness and readdress the structural changes that underlie contemporary homelessness.

CONCLUSIONS AND RECOMMENDATIONS

Several solutions have been proposed to solve the problem of the high rate of mentally ill people among the homeless population.

Some solutions address the problem of the organization of mental health facilities and aim to prevent mentally ill patients from ending up in the street. Homelessness is the result not of de-institutionalization as such but rather of the way it has been implemented. Homelessness among mentally ill patients is proof of a shortage of relevant resources and of obstacles to obtaining access to facilities for the mentally ill. Therefore, the commitment to the de-institutionalization policy should be confirmed, but increased efforts should be made to support the completion of a public mental health care system accessible, coordinated and complete, and emphasis should be put on housing and income support.

Several authors have been pondering the part to be played by the hospital in the treatment of homeless mentally ill patients. Although none of them advocate going back to institutionalization, several admit the need for hospitalization in certain cases and hope that accessibility to this type of service can be facilitated. In an experimental project, Bennet *et al*. [42], for example, have analyzed the potential value of short-term hospitalization in the treatment of this population. The programme, designed for vagrant mental patients, aimed to improve access to short-term treatment in a

hospital. The authors conclude that this type of treatment is underused, whereas it would be beneficial for a large number of the homeless mentally ill.

Christ and Hayden [43] consider psychiatric hospitalization as an opportunity to identify patients who could benefit from the help of social services to prevent them from entering a persistent cycle of vagrancy. People at high risk of becoming homeless should be identified as soon as they are admitted to the hospital and referred to social workers.

The traditional care system can and must be improved, and most authorities also agree on the need for services to be reserved for the vagrant mentally ill. Great efforts have been made to find innovative solutions adapted to the seriously and chronically ill mental patients who become homeless. The following characteristics of the homeless may affect the services and treatments to be offered to this population: their distrust of authority and of mental health care services, their marginal way of life, and their multiple needs.

Thus, commitment will be an important part of the services provided and will often constitute the first stage of the intervention. At this stage the importance must be stressed of winning the trust of the homeless, of first fulfilling their essential needs and the needs they express, the need for flexible, non-stigmatizing and easily accessible services, and the importance of reaching those people in their natural environment and of developing stable social supports. Several programmes aiming at enforcing commitment are described in the specialized literature. Often called ''outreach programmes'', they aim to reach the vagrant mentally ill patients most resistant to treatment and to improve their access to the health care system. In this type of programme, the vagrant mental patients are reached where they are, whether in the street or in public places, vacant plots or shelters.

Another element important to consider in the offer of services, is to ensure access to cheap or supervised housing. For Shore and Cohen [44], housing should be considered a primary component of the services, which should include diversified levels of supervision and support to fit the particular disabilities of each patient. According to these authors, the need to house homeless people is forcing psychiatry to play a part in the development of supervised model lodgings to keep the most seriously ill mental patients in the community.

Some authors have insisted on the importance of taking into account, in programming the services, the survival strategies and skills developed by homeless people in the street. Important skills are indeed required to survive in such an environment. The punctuality regarding admission times to the shelters, or meal times in soup kitchens, for example, requires a cyclical sense of time, and therefore great adaptability. Homeless mental patients have a remarkable capacity for adaptation and coping. The fact that they

succeed in satisfying their basic needs suggests some degree of self-control and of skill regarding the requirements of street environment and shelters. Efforts towards rehabilitation must use this adaptation potential, take into account the strengths and weaknesses of vagrant mental patients and provide them with services designed from the skilfulness and creativity of their survival strategies. For example, their independence can possibly lead them towards a kind of rehabilitation. In short, we must offer them the opportunity to use the resources they have developed, but in a more secure environment.

The ''empowerment'' approach, a philosophy and a social readaptation technique, has been adopted by several authors. In this approach, patients are encouraged to participate fully in identifying their needs, in deciding their goals, and in establishing the terms of the help programme. Thus, their implication contributes to the self-determination and autonomy of the patients.

Other types of treatment are also proposed. Murray and Baier [45], for example, report on an approach of the therapeutic environment type, which has been tried in a transition home for homeless people with mental disorders. Another example, reported by Caton *et al*. [36], describes day-care treatment in a shelter.

To meet the numerous needs of this population, several authors note the importance of a complete range of services, which should include a mobile team on the streets (outreach) and an appropriate number of supervised communal lodgings. It should also include access to medical care, to psychiatric and rehabilitation services, to emergency services for mentally ill patients (whether they are homeless or not), to case management services, to general social services and to long-term hospitalization services, when necessary.

Other authors have stressed the need to coordinate services for the homeless, and that this coordination should integrate also the services offered to the whole population. According to Talbott and Lamb [46], everybody's responsibilities must be well established and financial resources appropriate. Some support the idea that services should be integrated into shelter programmes and that a specialized and variously trained staff should provide them on the spot and send some patients to services they know to be accessible. Finally, some programmes have recently been designed to answer the more specific needs of vagrant patients with a double disorder.

These recommendations concern essentially the health system and eventually the social system; however, many authors advocate interventions directed towards prevention: prevention of substance-related disorders among the mentally ill, integration of the diverse agencies involved in housing and social benefit as well as health. But the ultimate goal is to prevent the childhood disorders that render people vulnerable to homelessness, and

to develop interventions for children living in social difficulties in order to avoid replication of parents' situations in children.

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CHAPTER

10

Mental Health Consequences of Disasters

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INTRODUCTION

One of the classical functions of epidemiology is to identify risk factors for the development of disease with the aim of prevention. In psychiatry the debate on the relative importance of environmental as opposed to genetic risk factors has been more profound than in other areas of medicine, even to the point where it was at times shaped more by ideological points of view than by scientific facts. In this discussion, the potential of external events to cause, or at least trigger, the onset of mental disorders in previously healthy individuals has played a central role. The study of life events in general, and that of severe traumatic events in particular, appears to provide a suitable paradigm within which this debate may be based on sound scientific discourse supported by research. At this moment, there is a large body of evidence to show that the risk of depression and anxiety disorders is increased considerably after a severe loss, such as the death of a spouse [1, 2].

It has also been firmly established that extreme events, such as natural and human-made disasters, often have short- and long-term psychological impacts that far exceed the degree of medical morbidity and mortality that ensues [3]. Indeed, Lechat [4] defined a disaster as a ‘‘disruption exceeding the adjustment capacity of the affected community’’. The scale on which disasters affect whole communities has clearly shown the public health interests at stake after these events. It also brought to attention the complex societal and cultural dynamics that mediate these effects.

Focusing on the impact of such events, a number of reviews have shown that a considerable proportion of the population affected by such events

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suffers from short-term and long-term psychological impairment [5, 6]. In many cases a clearly definable syndrome, now called post-traumatic stress disorder (PTSD), emerges in a substantial number of people exposed to such events [7, 8].

The importance of these findings is underlined by the fact that affective disorders and anxiety disorders such as PTSD are extremely common in the general population, and contribute considerably to the total burden of disease worldwide [9, 10]. The identified risk factors, i.e., traumatic events, are also quite common. To illustrate this point, an estimated 15–35% of the population in the USA experience events such as fires, floods or other disasters. Rates of PTSD among the general population may vary from 5% in men to 10–12% in women, and may be as high as 60–80% among victims of traumatic events. In so far as traumatic events or at least their consequences are preventable or treatable, post-disaster stress prevention is a necessary and feasible public health target.

However, it has also become clear that there are many factors which modify outcomes and that the research in this area is riddled by numerous methodological pitfalls. Some of the world's worst disasters have occurred in Third World countries, where applying Western research measures may not adequately capture the manifestations of trauma reactions. For example, the two instruments that were most widely administered by Soviet researchers after the Chernobyl accident were the Impact of Events Scale [11] and the 12-item version of the General Health Questionnaire [12]. Somatization and neurasthenia, which are less frequent in Western settings, were not included in these studies, and ''heart pain'', which is a culturally specific expression of sorrow, was also not evaluated. Hence our information about the psychological response to Chernobyl is limited by the choice of measures that are preferred and useful in Western settings.

Many disaster studies continue to rely on volunteers or litigants seeking compensation rather than representative samples of survivors. Most studies continue to be cross-sectional, with data collection occurring at arbitrary points in time following the event. We therefore have a somewhat limited understanding of the evolution of symptoms over time and the extended long-term effects of natural and human-made disasters. Moreover, our knowledge about the effectiveness of early intervention and treatment strategies for PTSD and related syndromes remains largely inconclusive. Finally, the role of social and economic support in modifying the effects of the trauma has only rarely been studied.

In this chapter we will describe the advent of research on disasters and its place in life event research in general. We will describe the current state of the art of this field and will analyze the strengths and weaknesses in this research area. Finally, we will outline a number of promising future directions for this area of research.

HISTORICAL OVERVIEW

Starting from the work of Janet and Freud and early descriptions of ''irritable heart syndrome'' and ''shell shock'' among soldiers of the American Civil War and World War I [13, 14], research on high-impact events, such as disasters and life-threatening occurrences, and more ordinary life events has been under way for at least a century. Since World War II, a number of studies have assessed the emotional consequences of natural disasters, such as hurricanes, tornadoes, floods, volcanic eruptions, and earthquakes, and more recently technological and human-made catastrophes, such as the nuclear power plant accidents at Three Mile Island (TMI) in the USA and Chernobyl in the Ukraine [15–17], the Nazi Holocaust [18, 19], and the Cambodian massacre [20].

The work of Brown and Harris [21] was one of the first attempts to study the influence of negative life events by a systematic, objective measurement approach and a prospective design. This pioneering work convincingly showed for the first time that threatening life events are potent risk factors for depression and anxiety disorders. The life event literature has since then provided an important conceptual framework for disaster research as well, and the latter may be seen as a special form of the former. Indeed, disaster research offers an opportunity to avoid some of the methodological problems that are typical of life event research in general, because disasters by definition strike entire communities and not just certain, possibly selected, persons.

Problems related to conducting assessments that incorporate post hoc subjective evaluation of events have hitherto plagued the stress literature [22, 23]. By studying populations exposed and not exposed to disasters of known severity, this area of research is much less hindered by the difficulty of defining life events in objective terms and of disentangling personality-related risk factors, which may lead to increased risk of exposure to life events as well as selective reporting behavior.

From a substantive point of view, the renewed interest in the mental health consequences of extreme, traumatic events acted as a strong stimulus for the field of disaster research. Research on Nazi concentration camp survivors (e.g., Eitinger [18]) and on Hiroshima survivors [24] identified cardinal symptoms that were later incorporated into the definition of PTSD. The aftermath of the Vietnam War, with thousands of previously healthy young men returning home and apparently psychologically harmed by the war, was probably the single most important factor leading to the wide recognition of traumatic stress as a mental health hazard. Eventually this led to the formulation of the PTSD in the DSM-III. A second factor that contributed to this wider acceptance of the concept of psychotrauma was the renewed interest in a number of psychiatric disorders attributed to sexual

traumatization of women, such as borderline personality disorder and dissociative disorders. Before that, the trauma model had been practically abandoned in psychiatry since Freud [25] launched his ''forbidden fantasy'' hypothesis as an alternative explanation for the observed relation between mental disorders and reported sexual abuse. Several cultural developments in the field of sex roles have helped place sexual trauma as a potential pathogenic factor back on the research agenda.

From a methodological standpoint, with the publication of DSM-III and the introduction of operational criteria for PTSD, disaster research benefited from new developments in standardized diagnostic interview schedules, such as the Diagnostic Interview Schedule (DIS [26]) and the Composite International Diagnostic Interview (CIDI [27]), and subclinical measures, such as the Impact of Events Scale [11]. The use of such instruments brought new rigor into case definitions and allowed for comparisons with findings from general psychiatric epidemiologic studies on the occurrence and persistence of PTSD and post-traumatic stress symptoms in disaster-exposed and control populations.

Greater attention has also been given to including representative samples and a comprehensive array of risk and protective factors. While it is often difficult to obtain representative samples in the wake of the chaos that follows many disasters, innovative approaches, such as that employed by Havenaar *et al*. (28) in studying the mental health impact of Chernobyl, have been proposed.

DISASTER RESEARCH AS AN APPLICATION OF PSYCHIATRIC EPIDEMIOLOGY

The earliest disaster studies were case studies of specific events. Parallel with developments in research methods in epidemiology generally, particularly case-control methodologies, disaster researchers began to apply the basic principles of epidemiology to understanding the psychological aftermath of these events. For example, the case-control design was recently applied by Asukai [29] in a study of PTSD among firefighters who had been called in as rescue workers after the Sarin nerve gas attack in the Tokyo subway. They found that PTSD occurred more frequently in firefighters hospitalized with signs of Sarin poisoning, while most non-PTSD subjects had no, or only mild, intoxication.

Disasters can also be conceptualized as ''natural experiments''. Like experimental research, disaster studies often involve careful comparisons of exposed and non-exposed cases. Indeed the design of the prototypical disaster study can most readily be understood as an extension of a modified cohort design. Most of the time, however, we do not know baseline morbid-

ity level of the population affected by the disaster and must infer the level from epidemiologic studies of demographically similar populations.

There have been some notable exceptions, however, in which a population happened to have been studied prior to the disaster, and then a post-disaster follow-up was performed. One example involved a population in Puerto Rico who had participated in a psychiatric epidemiologic study modeled on the Epidemiologic Catchment Area (ECA) study [30] in 1984 [31]. The following year, torrential rains hit the island, causing extensive mudslides and leaving 180 people dead, 4000 in shelters, and 19 000 with serious property damage. In 1987, the investigators re-evaluated a group of disaster survivors ($n = 77$) and controls ($n = 298$), using a Spanish-language version of the Diagnostic Interview Schedule Disaster Supplement [32]. At approximately the same time, an area in St. Louis, Missouri, that was also part of the ECA study, was struck by a series of disasters. First devastating floods swept through the area, causing five deaths and necessitating the evacuation of about 25 000 people. Evacuees from the residential area of Times Beach were later informed that they could not return to their homes because of the contamination of soil and water with dioxin. The discovery of a radioactively contaminated water well and more floods and a tornado followed over the next few months. In this study, pre- and post-disaster interviews were conducted on 44 subjects exposed either to flood alone, dioxin, tornadoes, radioactively contaminated water, or multiple events (n's for the different exposures ranged from 2 to 20). The results showed that there were significant increases in depressive, somatic, and PTSD symptoms in the affected populations in both Puerto Rico [33–35] and St. Louis [36, 37]. In another example, Trevisan *et al*. [38] were conducting a 5-year follow-up of Italian workers participating in a study of coronary heart disease risk factors when an earthquake struck. Workers whose examinations were performed afterward had significantly higher heart rates, serum cholesterol levels, and triglyceride levels than those whose evaluations were completed before the earthquake. Yet another example involved a study of depressive and post-traumatic stress symptoms after an earthquake in California. In this study, a group of university students had completed a set of questionnaires 10 days before the earthquake struck. They were re-evaluated 7 weeks post-disaster. The authors found that pre-event symptomatology was the strongest predictor of post-disaster symptom severity [39].

CURRENT STATUS OF DISASTER RESEARCH

The uniqueness of each disaster and the different methodologies employed in each study make it difficult to integrate the findings for adults and children, although a number of review papers have appeared [e.g., 5, 6,

18, 40–49]. Moreover, not only are disasters unique events, occurring in socio-culturally unique places, but their evolution and severity can be quite disparate. The number of deaths, extent of damage, organizational response, and post-disaster stressors will all influence the psychological impact. And, of course, studies that sample litigants or help-seekers will show stronger effects than studies of random samples of survivors.

Nevertheless, attempts have been made to assign a range in rates of psychopathology (e.g., PTSD/depression/somatization) to post-disaster survivors. Weisaeth [49] estimated that the 1-year post-disaster prevalence of psychological morbidity was about 20%, but it might be as high as 50%. Indeed, in some disaster studies, such as the Chowchilla bus kidnapping [50] and the Nazi Holocaust follow-ups, the rates have been 100%. We present these average estimates with caution, however, because, as noted earlier, many of the worst disasters occurred in developing countries [49, 51, 52] and in the former Soviet Union after these reviews appeared. The effects of these devastating disasters appear to be much worse and hence might increase the average figures substantially. For example, the rates of psychiatric morbidity reported in recent studies of natural disasters in Sri Lanka, Colombia, and India were 75%, 55%, and 59%, respectively [53].

The most frequently reported symptoms in adults in the aftermath of natural disasters and human-made disasters are somatic complaints, depression, anxiety, and post-traumatic stress symptoms, particularly intrusive and avoidant symptoms. These symptoms have been described in survivors of earthquakes [39, 53–63], floods [e.g., 64–66], hurricanes [67], volcanos [68], mudslides [34, 35], cyclones and tornadoes [69–73], TMI [41, 74, 75], Chernobyl [28, 76, 77], industrial accidents [e.g., 78], and a food-poisoning epidemic (toxic rapeseed oil [79]). The clustering of such symptoms is sometimes referred to as the ''disaster syndrome'' or the ''disaster-reactive psychopathological repertoire'' [35]. These symptoms may not reflect separate disorders [80], but rather may represent a complex trauma syndrome [13]. While these symptom domains are elevated after natural and human-made disasters, somatic complaints and health-related anxiety are more common after technological incidents. Moreover, it appears that these symptoms are more enduring and chronic after technological catastrophes in which people come to believe that their health has been compromised by the exposure. This phenomenon has been particularly well documented in survivors of Hiroshima [81] and Chernobyl [76, 77, 82, 83].

Similar symptoms have been described in research on child survivors of disasters, such as floods [84], hurricanes [e.g., 85–88], cyclones and tornadoes [89, 90], a bush fire [91], and a blizzard [92, 93].

In addition to the presence of somatic and psychological symptoms in substantial proportions of survivors of disasters, several physiological manifestations of stress have now been reported in disaster studies, such

as changes in blood pressure, catecholamine excretion in urine, and changes in immune function [94–96].

Although increased symptom rates and psychophysiological changes have been well documented, the clinical relevance of these findings is not entirely clear. Most studies have reported outcomes on dimensional parameters using self-report methodologies. Studies that have instead used clinical criteria such as DSM-IV or ICD-9 based on clinical interviews as outcome criteria have yielded more equivocal results. For example, in the prospective ECA sample in Missouri described above, only increased symptom rates were reported. No increased incidence or prevalence rates of clinical PTSD or other mental disorders were observed [36]. As will be further discussed below, increased rates of disorders have thus far been mainly found among subjects from high-risk groups, notably mothers with young children and evacuees.

The same holds true for the biological parameters that have been measured. Most of these findings are well within the range of normal variation and, importantly, it should be remembered that even an abnormal laboratory finding is not tantamount to disease [97]. One finding, however, underscores the public health importance of these phenomena. Specifically, no matter how subjective these health complaints are, they lead to marked changes in medical consumption and other health-related behaviors such as reproduction rates [98].

PRE-DISASTER RISK FACTORS

In the absence of baseline data in most studies, the literature on pre-disaster risk factors is rather limited. To date, the most reliable predictors of post-disaster psychopathology are female sex and especially being a mother of young children [16]. After the TMI disaster, women with young children showed significantly increased rates of anxiety and depressive disorders compared with non-exposed controls, as assessed with the Schedule for Affective Disorders and Schizophrenia–Lifetime (SADS-L) (risk ratio 3.4 for new cases [99]). In a within-sample analysis of risk factors among a large population sample in Belarus exposed to the Chernobyl disaster, Havenaar *et al.* [16] found that being a mother was associated with a 4–5-fold risk of having a DSM-III-R anxiety disorder and an almost 3-fold risk of any psychiatric disorder. However, these variables are also risk factors for poor mental health in non-disaster studies [100–102]. Nevertheless, the consistency of the findings in disaster studies suggests that secondary prevention efforts addressing PTSD, depression and anxiety should target women, especially those with young children.

It is also important to note that the types of behaviors that are more likely to be seen in men, such as substance abuse, have only rarely been included

in disaster studies. Thus, it remains to be seen whether the difference we currently observe is due to limitations in measurement (e.g., a circumscribed view of the phenotype!).

It is noteworthy that the elevated rates of psychopathology in women have also been found in some studies of children, such as some of the studies after Hurricane Andrew [85].

Several studies have shown that a personal history of psychopathology is a risk factor for poor mental health after a disaster [6, 47, 75, 100, 103]. The Bromet *et al*. research program on the mental health effects of the 1979 nuclear power plant accident at TMI was the first large-scale study to use a semi-structured diagnostic interview schedule. That study showed that pre-accident history of depression and anxiety disorders was among the most significant predictors of post-TMI depression and anxiety.

Long-term outcome has also been linked to mental health history. For example, Weisaeth [104] showed that outcome 4 years later was significantly influenced by pre-exposure psychological functioning. Similarly, McFarlane [105] found a significant association between a history of psychiatric disorder and chronic PTSD in a large group of firefighters in Australia assessed after a major bush fire. These findings are consistent with general population studies of PTSD showing that a personal history of psychopathology is an important risk factor [106–108]. However, findings in this area are not entirely consistent. In the only prospective study available, Robins *et al*. [36] did not find that after exposure to floods or to dioxin, people with a history of mental health problems had a higher than expected rate of new or recurrent episodes of psychiatric problems, either at the symptom level or at the level of clinical disorders. However, this study may have been ''underpowered'' and hence unable to detect this effect. Retrospective reporting bias could of course influence the findings in these studies, since the psychiatric history reports are retrospective in nature.

There is also growing evidence that disaster survivors who were exposed to traumatic life experiences before the event are more vulnerable to their impact [55]. There is also evidence that children of survivors of severe traumatic events, such as the Holocaust, may be more at risk of developing PTSD and related disorders [109]. While this area needs further investigation, it is consistent with Turner *et al*.'s [110] research showing that individuals exposed to early life trauma, continuing strain and acute stressors are at increased risk of adverse mental health outcomes.

In child survivors, it appears that the most important risk factor is the mothers' response to the disaster [48, 89, 91]. Several child disaster studies, including our TMI work on very young children [111] and school-age children [112], as well as the study by Laor *et al*. [113] of preschool children after the Scud missile attack on Tel Aviv (Israel), found that mothers' response was the more significant factor. However, both the age of the

sample and the extent of involvement in the disaster can influence the contribution of the mothers' response. For example, in a study by Pynoos *et al*. [114] of elementary school children in Los Angeles exposed to a fatal sniper attack on their playground, proximity to the violence was the most important predictor of type and number of PTSD symptoms. In a subsequent study of the Armenian earthquake, Pynoos *et al*. [115] demonstrated a similar correlation between proximity to the epicenter of the quake and severity of children's post-traumatic stress reactions. March *et al*. [116] showed a clear dose–response effect, with the greatest PTSD symptoms reported by children who witnessed an industrial fire and had a relative or friend hurt or killed, followed by those with a relative or friend who was hurt or killed (only), and those who witnessed the event (only), with the lowest level among those with none of these exposures.

DISASTER AND POST-DISASTER RISK FACTORS

The severity of the exposure is by far the most important disaster risk factor for the development of post-disaster psychiatric morbidity [42, 75] (Table 10.1). One of the most poignant descriptions of survivors' coping with mass destruction comes from descriptions of the survivors of Hiroshima in which an American psychiatrist, Robert J. Lifton [24], recounted the survivors' horror and loss of feeling from witnessing mass death and dying and being unable to respond to calls for help, a phenomenon later referred to as psychic numbing. Indeed, this early description was the forerunner of the current nosology of PTSD. Severity can be measured by the magnitude of

Table 10.1 Risk factors for the development of mental disorders in people exposed to a disaster

Period	Risk factor
Pre-disaster	Female sex
	Motherhood
	Prior psychiatric history
	Prior traumatic experiences
During disaster	Severity of exposure
	Death of loved one or close friend
	Physical threat
	Perceived lack of control
Post-disaster	Evacuation
	Inadequate practical support
	Inadequate emotional support
	Inadequate professional intervention

the destruction (realized or anticipated, as in the case of a nuclear power plant accident), death of loved ones [117], severe physical harm, perceived lack of control, stressors incurred during the evacuation and/or relocation [70], and threat or fear of future similar events [42, 118]. The link between exposure severity and PTSD was recently illustrated in a British study of survivors of a rail accident, showing that those who were trapped, witnessed death, or felt at risk of death experienced more PTSD symptoms than other survivors [119].

Research on stressful life events has demonstrated that social support often serves to buffer the adverse effects of stress on mental health. Social and economic support are important aspects of the recovery environment in the post-disaster period [e.g., 43] but can themselves be affected by a disaster [65, 120]. To date, the findings on the precise role of social support in disasters have been inconsistent, with some studies finding that social support buffered aspects of post-disaster morbidity [e.g., 64, 120] and others finding direct effects but not a buffering role [e.g., 62, 99]. In addition, the contributions of social support have been inconsistent across demographic groups. For example, in a study of the *Exxon Valdez* oil spill in Alaska, Palinkas *et al*. [121] found that, in Americans of European descent, perceived family support buffered the effects of exposure on depressive symptoms (assessed by the Center for Epidemiologic Studies Depression scale [122]), but not in Native Alaskans. Similarly, Solomon *et al*. [123] reported that marital support reduced disaster-related symptoms in men, but not in women. In our TMI research, we found no evidence of a buffering role for social support in mothers of young children, but in school-age children, a positive family milieu buffered the effects of the ensuing stress on their current mental health [112].

Evacuation as such is probably a risk factor as well, although its effects have received little attention in the disaster literature. Havenaar *et al*. [16] found that among inhabitants in a Belorussian region that was severely exposed to radioactive fall-out from the Chernobyl disaster, those who had been subsequently relocated to cleaner areas in the region had an increased risk of psychiatric morbidity 5 years after the event (odds ratio 3.8). Evacuation as a risk factor probably represents a complex of long-term difficulties, such as socio-economic adjustment problems in the new environment, loss of social support, and even stigmatization, as was the case for Chernobyl evacuees. The risk of inducing mental health problems by evacuation should be one of the factors weighed against the risk of other potential harm in decisions to evacuate.

Given the importance of alleviating the deleterious effects of stress caused by disasters, intervention research following disasters, both in the short term and in the long term for events with chronic sequelae, is needed. There is growing evidence from naturalistic follow-up studies of disaster

victims and clinical studies of traumatized patients that ''crisis support'' (e.g., people who listen and provide practical and emotional support) is a therapeutic tool with potentially long-term impact. Indeed, Dalgleish *et al*. [124] reported that greater crisis support when the ferry *Herald of Free Enterprise* sank predicted fewer avoidance symptoms at 6-year follow-up. Vernberg and Vogel [125] noted that prevention of psychological trauma after disasters requires rapid and appropriate crisis responses from the mental health community just as in the military four principles for treating psychiatric casualties during war: immediacy (early intervention), expectancy (the attitude that the patient will soon return to duty), simplicity (in the forms of treatment), and centrality (of facilities).

Besides crisis counseling, other types of intervention strategies after disasters include public information, community education, individual and family outreach, and recovery counseling [126]. The World Health Organization's Division of Mental Health provides training material and professional services when disasters strike, with the long-term goal of increasing self-reliance in coping with the needs of disaster victims [9]. Other specific materials are also available from international agencies (see Danieli *et al*. [127] for available resources). The role of the mental health professional can range from assisting with public education and media responses to bolstering indigenous support networks, supporting family members who have lost a loved one, and working with the Red Cross and other relief organizations to provide psychological first aid [44]. New forms of psychological and pharmacotherapeutic treatments are being developed and tested on survivors of trauma [128] and traumatic life events such as rape [129]. Unfortunately, although a number of specific treatments have been designated as ''probably effective'' by the American Psychological Association [130], the evidence for prevention and intervention strategies remains fragile. Indeed, some studies have even shown detrimental effects [131].

The complex nature of disasters and disaster-induced psychopathology (e.g., acute and chronic PTSD, depression, anxiety, substance abuse disorders, and somatization), and the widely differing cultural contexts in which they may occur, challenge the design of clinical interventions. Research is currently being conducted on issues such as differential improvement after sequentially administered vs. simultaneous symptom-specific treatments, medications alone vs. cognitive-behavioral treatment vs. both, and effectiveness of different modalities for children (debriefing, pharmacological interventions, individual psychotherapy, and family therapy) [125].

Far less is known about the impact of temporary shelters or settlements on mental health. Nevertheless, many recent disasters have produced large refugee populations interned in camps without adequate sanitary conditions, nutrition, privacy, or safety [132, 133]. The survivors of Hiroshima

and Nagasaki and those evacuated from the area around Chernobyl were also subjected to social stigma by both health care professionals and lay members of the community. This aspect of the post-disaster experience has not been adequately studied or discussed, although existing data from some interned populations suggest that the rate of PTSD stemming from this experience is substantial [132].

FUTURE DIRECTIONS FOR DISASTER RESEARCH

Disasters may be regarded as natural experiments from which inferences can be made about the relationship between extreme stress and mental as well as physical health. Disasters affect entire communities, and not just a few selected individuals. Moreover, they usually are not the result of actions related to the personality of their victims, a confounding relationship that has troubled life event research in individuals.

Disaster research has largely affirmed the previously formulated hypotheses on their mental health consequences. However, apart from that, it has not really led to new insights. One of the functions of epidemiology is to complete the clinical picture [134]. While disasters offer this opportunity, particularly for a cross-cultural understanding of stress reactions, the research has been constrained by the reliance on preformulated outcome measures, lack of in-depth and culturally sensitive knowledge, and cross-sectional approaches to research. One illustration, as noted earlier, is the inadequate attention to somatic manifestations of stress, which in developing countries is known to be the major mode of expressing distress. Our respective studies of Belorussian and Ukrainian victims of the Chernobyl accident demonstrate the powerful role of somatic complaints in these populations.

We need to expand our vision of ''high-risk'' populations. To date, we have used demographic characteristics and psychiatric history to define high-risk groups. However, it is known that certain populations are more prone to disasters (e.g., living on the ''wrong side of the tracks'', near industrial sites, in flood zones, etc.). Therefore, confounding with other environmental factors may be problematic. And even though disaster research may be less prone to distorted reporting behavior than life event research in individuals, the observation at TMI that mere information about the possibility of a disaster may induce a post-disaster syndrome in a substantial number of those exposed to this information [135] demonstrates that appraisal factors nevertheless play an important role in determining outcome. Media coverage and opinion leaders play an as yet poorly understood role in moderating collective appraisal after disasters. More in-depth, qualitative research may be needed in this area to generate testable hypoth-

eses for future research and to elucidate the complex interaction between individuals, groups and societies exposed to disasters.

Even though many disasters produce chronic sequelae, most follow-up studies of disaster victims have been short term. There are precious few examples of long-term studies, and those that have been done on technological disasters show significant elevations in psychopathology 15–20 years after the event. In order to maximize the potential of the ''natural experiment paradigm'' of disaster research, such studies should ideally be conducted among previously assessed survivors undergoing such events. Because epidemiological population studies are conducted at regular intervals in many countries around the world, and because disasters are so common, it is, in principle, feasible to include relevant parameters in these surveys. Future studies of disasters should also venture more deeply into the investigation of biological parameters, especially further investigation of the hypothalamic–pituitary–adrenal axis and measures reflecting on psychoneuroimmunological responses [109].

Finally, more research is needed on the subject of prevention and intervention. So far the available treatment modalities have emphasized emotional expression as a means to prevent being overwhelmed by trauma. However, as Bowman [131] has pointed out, several studies have shown that emotion-oriented coping is less effective than problem-oriented coping. This may be one of the reasons why the strategies applied today have failed to show positive results across all studies. Certainly, emotional expression as a form of therapy is a typically Western approach. In most Asian cultures, for example, emotional expression is believed to be detrimental to health. More culturally sensitive and perhaps more problem-oriented intervention strategies need to be developed and tested.

CONCLUSIONS

Psychiatric epidemiologic research on the mental health consequences of disasters has clearly demonstrated that these disruptive events have significant long-term deleterious effects on mental health. Moreover, there appears to be a dose–response relationship between trauma and disorders such as PTSD, establishing trauma as a causal factor in eliciting certain psychiatric outcomes. Other risk factors include being a mother of young children, having a prior psychiatric history, and having inadequate emotional, practical, and/or professional support.

At the same time, it is clear that a majority of people exposed to disasters do not develop PTSD [102] or other mental disorders. Thus, the experience of trauma is a necessary but not a sufficient condition for the development of post-disaster psychopathology. The nature–nurture debate which originally

dominated this research field has now been largely superseded by more sophisticated gene–environment interaction models, which leave room for a wide array of genetic as well as acquired vulnerability factors. From a public health perspective, the important of this lies in the possibility of identifying clinically relevant and potentially amenable risk factors. There is now firm evidence regarding the development of PTSD and other mental disorders in identifiable risk groups (Table 10.1) and there is a substantial body of knowledge showing widespread subclinical psychopathology, both of which are associated with impaired quality of life and increased health care costs.

Unfortunately, there is a dearth of disaster studies with longitudinal designs or extended, long-term follow-up, particularly in developing countries. Thus, while high-risk groups in need of short-term services can be identified, we still have little knowledge of the relationship between short-term and long-term adjustment. Specifically, we have little knowledge of the evolution of disaster-related symptoms and syndromes and the risk factors associated with the course (as opposed to the onset) of these disorders in men and women of different ages and different socio-economic and national backgrounds. Conversely, it is imperative that we learn more about the variables that promote health and protect against adverse mental health outcomes after disasters. Such knowledge can then be used in the formulation of potentially successful interventions. New interventions should be careful to take cultural factors into account. They should maximize the ability of people to cope with stressful circumstances and to make sense out of what is happening to them. It is a well-known observation that disasters and periods of extreme collective strain can sometimes strengthen social cohesiveness and thus enhance the resilience of its members. Elucidation of the optimal type and quantity of supportive interventions will be one of the main challenges for this area of research in the near future.

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CHAPTER

11

Mass Media and Psychiatry

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INTRODUCTION

We are now immersed in a global civilization. Within the developed societies, almost all the daily routines of our lives are common to all nations: the products that we usually consume, the acquired customs, etc., all form part of a common ritual. A whole series of similar social forms have been developed; the local identities have been homogenized through the diffusion of lifestyles and values. The role of the media is essential in this so-called globalization. Who has not heard in recent years the sentence, ''We are living in the 'information society' ''? Identifying our times by such an extended concept is, for many, little more than a figure of speech. However, an update on the role that the media and the information systems play in modern society is necessary before addressing the matter that we are to discuss, that is, the relationship between psychiatry and the media.

THE ROLE OF THE MEDIA

Among the different elements that make up the field of telecommunications (telephone, online connections, fiber optic networks, etc.), the principal engine that moves information in the society is the media. The great revolution brought about by the new technologies has resulted in an immediate radical change in the world of journalism. The media have multiplied and have become a discipline practiced in every country worldwide by thousands of professionals. We could even say that a mercantile aspect of information has been discovered, driving the growth of capital in the sector.

Just as we live in a world where habits and customs tend to become unified and standardized, so we are seeing an intense process of concentration in the media. The same companies control newspapers, magazines,

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television networks, radio networks, editorials, movie distributors, and cable operators. The entrepreneurial concentration phenomenon has merged with the previously mentioned globalization to create important groups such as Bertelsmann, Havas, News Corporation, Pearson or Kirch. These groups are, above all, business holdings. Information and entertainment are their products. This concentration is motivated in part directly by the entrepreneurial spirit (growth objectives) and in part by the need to group the capital to offer the best products and services available.

The media are an indispensable component of the contemporary social structure. If they did not exist, society would be completely different. We live in an interconnected world where transmitted ideas and messages can generate, modify and eliminate attitudes and trends of opinion. We are continuously exposed to all sources of information. Our contact with the media is made continuous, intense and complex by the confluence of the channels, messages and the different uses given to the available information.

Television, radio and newspapers make up part of our daily life. Statistics presented by international organizations such as the United Nations Educational, Scientific and Cultural Organization (UNESCO) show that in the year 1970 there were 9275 million media units (television, radio, newspapers and magazines) while in 1996 this number increased to 12 345 million (television, radio, newspapers and magazines), showing a 33% increase. The most spectacular growth has been experienced in television and radio, with increases of 466% and 268%, respectively. The presence of television in the world's households has tripled in the period between 1970 and 1996, and that of radio has doubled. Furthermore, not only has the consumption of the above "traditional" media increased, but also the new media have experienced a spectacular growth. In the emerging sector the result of the "information technology era" is exemplified by media channels such as the Internet, cable television and satellite television.

The Internet, an unknown universe to society only 20 years ago, is presently one of the fastest growing media. In 1999, the Internet had more than 131 million users worldwide. In the year 2003, this number is projected to reach 350 million. Considering the level and rate of development of the population in general, this number is considered of great importance. The digital television sector has also shown important growth in the last years.

Not only is the number of media growing, but also the number of hours in which we are exposed to the media. Different audience studies show that in industrialized societies 90% of the population between 5 and 15 years old, 85% of the persons older than 15 years and 95% of the population over 65 years watch television. Audience data from North America show that television is watched around 6 hours daily by each person. In the case of Spain the number of hours of daily exposure to television is 4. Considering that the average person sleeps about 8 hours every night, these data confirm that

the time spent in front of the television constitutes one-third of the waking day.

Television deserves special consideration due to the great power of electronic images. Today, images have become one of the principal elements determining our life: the majority of the messages that we receive from the outside are transmitted through images, or images combined with words. These are one of the most important tools used by the media to get the message across to the audience.

Television's messages are directed to a more heterogeneous audience than newspapers'. The television audience receive the information realizing they are directly seeing or hearing it. Therefore, the general feeling is, ''I am seeing it with my own eyes, so it must be true''. The level of credibility of radio and television is, for this reason, the highest among all the media.

Television is often considered more an important tool of entertainment than a media communicator of information. This allows television to have a greater power of conviction than other media. The transmission of continuous information containing a high level of entertainment creates some sort of dependency on the part of the spectator, who regards television as a fundamental source of knowledge of reality.

Transformation into a source of entertainment is a phenomenon affecting all media in Western society, particularly in the Anglo-Saxon cultures, as, for instance, the great success of tabloids in the UK demonstrates. The trend is to lower the barriers between information and entertainment, the ''show potential'' of the issues being what determines their newsworthiness. Traditional journalistic genres, such as those offering information and opinion, merge, as do the criteria of the general public in interpreting what is really happening in the ''outside world'' and its importance. An example is the interview shows on television. Not so long ago, the interviewees were selected because of their links or relevance to a significant topic ''in the news''. That was the case of shows like *Larry King Live* on CNN. Recently, a new kind of interview show appeared, the ''talk show'', which takes the same format but selects its guests because of their entertainment potential rather than the informative value of their contributions. Some of these talk shows have found their own market niche, their own place in the broadcast offerings, like the US afternoon shows (Oprah Winfrey is a good example and also a pioneer). What is particularly significant, however, is that this same format sometimes takes the place of the traditional interview shows. This is the case of the evening programs, such as NBC's Jay Leno's *Tonight Show*. Yes, the alternatives for the viewers grow; they have a greater choice. But, at the same time, the usual informative formats tend to disappear, being replaced by the new ones.

Studies carried out by UNESCO show that, while the ear perceives 20% of the communications it receives, the eye perceives 30%. When we combine the ear and the eye, human beings are able to perceive up to 50% of the

communications they receive. Following is a short generic description of the principal characteristics of the media in relation to the influence that they have over the public opinion. Each form of the media presents a series of limitations that depends on its technical support. This determines the manner in which the messages are created and the type of audience that will receive these messages.

The print media (newspapers and magazines) characteristically offer information that is more extensive and reflexive than that offered by the electronic media. They have more time to elaborate its contents. Their public has a higher level of education and cultural knowledge than the audience of radio and television. However, it is more restricted.

There is a part of the print media that is worth analyzing in some detail. It can be called ''society'' or ''local happenings''. It is simply the section where various local occurrences are reported, often crimes. The information in these sections can be treated in many ways because they tell the reader about things a little out of the ordinary taking place in a city or region. In the case of Spain, this section is known as ''*sucesos*'' (''happenings''), and it has a rather negative connotation because it usually reports stories that are easily taken out of context. Furthermore, with reference to the world of psychiatry, this section is usually where the stigmatization of mental disorders takes place, because it carries stories of how people suffering from mental disorders behave as a result of their condition.

The other media—like literature, the cinema or television fiction—will not be analyzed in this chapter, even though there have been various rewarding studies by experts in mass communications on depictions of mental illness in fiction. However, it is important to mention that in many cases the characters depicted in literature or the cinema can show the reality of a mental disorder (like the Australian movie *Shine*). They sometimes even look at mental health issues from a less dramatic or even comic point of view (like *Frasier* or *Ally McBeal*). Their effect depends on a more subtle analysis of how these issues are dealt with. In any case, these programs can help the ''normalization'' of mental health issues in a faster and more efficient manner than media campaigns. The normalization effect is not only a mental health matter. Other social issues, once taboo, have been portrayed in movies or sitcoms, and then the level of social acceptance has risen dramatically. For example, take the recent inclusion of homosexual characters in sitcoms or movies (as in *Philadelphia*). Furthermore, this normalization has been essential to raise the awareness of AIDS and, especially, shift the public's attention from ''risk groups'' to ''risk behaviors'', and change the public's attitude to those affected by the illness. Thus, showing the reality of the illness contributes to its acceptance and treatment, and aids all those involved in research, raising funds or any other kind of effort to eradicate the disease and achieve an improved quality of life for those affected by it.

The negative side of this is that, too often, people affected by mental disorders are portrayed negatively in films and other media, as also are the mental health professionals, including psychiatrists. The patients are often portrayed as ''strange characters'' with behavior and habits that differ from the rest of the population. They are readily cast in comic roles.

The objective of this chapter is to show that the relation between the psychiatrists and the media can be improved and become closer in view of the advances, better knowledge and further development of mental health science.

Following the basic definitions of the media, and considering the advances pioneered by the sector in the last decades, we could conclude that the evolution of mass media is a reflection of the development of society. We can speak of a window on reality, but is what we see on television or what we read in the press the reality or an image of this reality? How far can the media go? Apparently, and considering the great variety of media available, we may get the impression that we choose the messages that we want to receive. However, this is not so, because each form of the media describes its own reality at its discretion.

We dedicate about 20% of our life to receiving information from the media, both supposedly objective information and messages that are publicity or advertising. Because the retention of information is very limited and is predetermined by individual tastes and preferences, the media represent a source that is very important to the generation and consolidation of beliefs and attitudes. Several studies have shown that in the development and growth of the individual the media play a more important role than family or friends. The media are now the most important socializing factor next to schools. Through the media, children and adolescents learn the basic ideas of the culture and find a learning focus that is credible to them.

However, it is necessary to say that the same media carrying out the task of acculturation are also directly or indirectly guilty of the transmission of stereotyped attitudes and ideas. The information transmitted by the media influences the way we act and think. Their controlled messages can modify the way in which we perceive and understand the reality that surrounds us. Studies show that the main source of information of the US population regarding mental health is the media. In Spain, recent surveys showed that health was the second most mentioned topic by the general population when asked what they want to be informed about by the media.

PSYCHIATRY AND THE MEDIA TODAY

Psychiatry, like other medical and technical specialties, has kept at a distance from the media, for several reasons, such as the use of very different

language codes by psychiatry and the media and a mutual misperception of the roles the two professions play in modern society. Recently, things have begun to change slowly, but there is still a need to understand better the reasons for that distance in order to act effectively to minimize it.

Just as some journalists specialize in specific areas such as economics, politics or current events, some specialize in health issues. However, very few professionals know in depth the field of mental health. The question remains whether there are journalists able to inform the public about these topics with the degree of correctness and sharpness that they display with other topics. However, this is not the only question that needs to be asked. For their part, the psychiatrists have to reckon with a series of limitations that complicate the task of providing the relevant information about this type of illness to the media.

The image that public opinion currently has of psychiatrists makes the labor of transmitting satisfactory concepts much more difficult. Psychiatry is considered a ''strange'' specialty, a ''different'' profession, and, thus, it is not treated as an integrated discipline in the ''information society''. It generates mystery and it does not promote knowledge. It is a profession that evokes an image of internal division probably as a result of the coexistence of different schools of thought, and the recent and still incomplete application of unified diagnostic criteria. Another common misconception is the confusion of the profession of psychiatry with other mental health professions, particularly psychology.

Another stereotype that the media share with the rest of the population is the classic distinction between ''body and mind'' or ''body and soul'', which leads to the identification of mental disorders as ''illnesses of the soul'', and therefore not to be dealt with as rigorously as other medical disorders. This misunderstanding has deep origins, since the word *psyche* in Greek means ''soul''. A similar misunderstanding is caused by the origin of the word *schizophrenia* (in Greek, ''divided mind''), with the consequent confusion between that disease and multiple personality disorder. These longstanding common beliefs about word meanings are difficult to overcome, especially since most of the diagnostic techniques and treatment developments which are helping psychiatry to become a truly scientific discipline are very recent.

All of these issues surrounding psychiatry are transmitted in the media and produce fear and attitudes of distance. Even today, at the beginning of the 21st century, one of the greatest problems that the field of psychiatry faces is underdiagnosis of mental disorders due to the reluctance of the patients and their relatives to consult a psychiatrist.

Psychiatrists are regarded as odd, alien, having a strange way of thinking and using a language that is difficult to understand and full of terms that are complicated and unknown to the general public. Often they are even

regarded as being ''as crazy as their patients''. People do not really know or understand what their job is. This may be due to the belief that this specialty does not have a rational basis. There is a general tendency to think that they ''do not cure'', that they act as the counselor, the good friend; often the treatment and its application are confused with a vision of the patients lying on a couch and revealing their most intimate secrets. Thus, not knowing psychiatrists' methods results in a series of myths in relation to their practices, which are related only to electroconvulsive therapy or psychiatric hospitals.

Psychiatrists are aware of these misinterpretations, as was shown in the survey carried out in Spain in 1998 for the development of the World Psychiatric Association (WPA)'s program ''Schizophrenia: Open the Doors''. In this study, 30% of the interviewed psychiatrists admitted that they felt neglected by the rest of the medical profession because ''they don't achieve much'' or because their medical specialty is considered to be ''of not much use''. The rejection increased to 52% among relatives of patients with schizophrenia, because they ''do not see how their family member is getting better''. The conclusions of this survey also show that psychiatrists could be contributing to these misinterpretations, since, despite the new developments in treatment of the disorder, only 7% agreed with the sentence ''They [patients with schizophrenia] are ill people with the possibility of recovery and participation in a family, social and working life if they receive the right therapies''. Sixty-two percent of the sample admitted feeling rejected by their patients because they do not accept or follow the treatments prescribed.

But why is it not possible for a society that is globalized, intercommunicating, and dominated by information technology to eliminate these stereotypes? We have all the necessary instruments, but there is a great lack of knowledge of the role played by psychiatrists in modern society. It is possible to transmit and spread the appropriate messages. However, psychiatrists are not familiar with the important role that the media play in society and the influence that they may have. They have not yet understood that they need to have a proactive attitude, like other professional disciplines, such as the economic and financial, or even the other medical specialties, which are taking advantage of the resources offered by the new information technology and the great media networks. However, in addition to the initiative needed on the part of psychiatrists, the media journalists also need to change their attitude, because at present they are helping to maintain the stigma of mental illness.

The time limitations inherent in the broadcast media and the limited space in print media lead to the generalization and the simplification of issues that cannot or should not be generalized or simplified. The preference for negative over positive information contributes to the inequality in the

quantity of the information available to the public to analyze issues and decide for themselves.

Rarely does the journalist actively seek good news, such as scientific advances or therapeutic developments. Normally, other sources need to stimulate the curiosity of journalists regarding the positive aspects of mental health science. The scientific findings are just one of the many examples available. For instance, when a social rehabilitation program is successful, someone must tell the media. Because ''nothing is happening'', journalists will not perceive the issue as newsworthy, and might not even hear about it, unless something goes wrong.

For this reason, it is important to maximize the contents of the information available, by choosing the most positive messages to communicate, rather than focusing on the negative aspects. The psychiatrist should choose, when facing the media, the angle from which to discuss mental disorders. For example, the psychiatrist might either talk about the percentage of people affected by a mental disorder who will not recover completely, or focus on the number of those who will recover when diagnosed and treated properly. While both figures are equally correct, focusing on the second has a much more positive effect on those seeking treatment or the people closest to those suffering from a mental illness.

Some experts suggest the use of a softer metaphoric language to overcome the burden associated with some disorders. But, in the case of mental health issues, this is more likely to perpetuate the myth than contribute to its clarification. Psychiatry is already surrounded, as described earlier, by too many legends, misunderstandings, and stereotypes. This discipline, and whatever is related to it, calls out for the contrary. The messages must be transmitted in a language code that is easy to understand but also emphasizes the medical basis of the discipline. Rather than looking ''prettier'', psychiatry must look ''easier'' and ''more medical'', but in a popular way, as other medical specialties have managed to do.

Occasionally, journalists use psychiatrists as their source of information, reporting their opinion on a given situation or issue. Even though there are difficulties in the communication between journalists and psychiatrists, it is important to mention that psychiatrists, as doctors, are considered credible and authoritative spokespersons by the media. Furthermore, the ''opinion of the expert'' is appreciated by the audience and gives credibility to the information, making it more acceptable. But, for the media to appreciate the support brought by the psychiatrist and for the establishment of continuous contact, it is necessary that when psychiatrists act as external consultants they create a solid image of their profession, supported by a firm position that provides continuous credibility, seriousness, veracity and respect.

The two disciplines need each other. The media have a pre-established series of informative topics that fit into the different sections such as science,

society, law and government. Each of these topics can be related to mental health in some way. It is important to have good sources capable of introducing correct and adequate information, in order to avoid any sensational tendencies, especially in cases of incidents, where incorrect terms are most often used.

Preferably, journalists specialized in health should handle mental health issues. However, it is important that they consult psychiatrists, in order to write stories that are correct, without errors in terminology or other matters, and to prevent any legal problems with some organization or affected group. In addition to correction of the material, mental health professionals can offer new views on the topics, so that a good collaboration not only does not restrict creativity, but even enhances it, by providing new story angles or topics.

From psychiatrists' point of view, there are important reasons why they need the media. Since psychiatrists are not able to provide a convincing view of the role they play in society, they should use the media to reach public opinion. The media can be the best tool to modify the attitudes of the public to psychiatry in order, for instance, to increase the opportunities to achieve an earlier diagnosis or increase the acceptance of treatment.

Mental health professionals often complain that the media use psychiatric labels incorrectly: for instance, schizophrenia is identified with multiple personality, psychosis with psychopathy. Furthermore, everyone of any sensitivity is perturbed when political parties or the traffic situation is described as ''schizophrenic''. For instance, very recently, the Spanish Minister for Development described a company's behavior as ''schizophrenic'', because its managers had first congratulated the government on its position regarding telecommunications infrastructure and, then, some months later, questioned the government's position on the matter. This comment, coming from such a major opinion leader, and incorporating this mistaken concept, was included in all media reports of the confrontation between the government and this corporation.

It is important to use the available information about mental health in the media from an interdisciplinary point of view, combining ample knowledge and taking advantage of the capacity of each area. In this sense, we have to struggle against the existing barriers. When contacting a psychiatrist, journalists are afraid that they may not be able to grasp and transmit the information in a useful and concise manner due to the complicated jargon used in psychiatry, as in other medical and technical specialties. They feel that the information obtained from the psychiatrists is too complicated and can interfere with their creative process. They have a tendency to believe that psychiatrists, instead of helping, will become an obstacle in journalistic work. Even when journalists decide to solicit the collaboration of psychiatrists, they doubt their willingness to cooperate, thinking that the

psychiatrists' personal and professional interests may affect the information provided.

On the other hand, when a journalist tries to contact them, mental health professionals tend to think that the information provided will be used to develop sensational topics: violent incidents, and criminal and delinquent issues among others. This idea stems from the fact that, historically, this has been the usual practice. Psychiatrists fear that their words will be taken out of context and serve to support an idea with which they do not agree, or may be used to further a one-sided image, limiting the scope of psychiatry, and embarrassing them not only in the public view but also in that of their peers.

PLACING SCHIZOPHRENIA IN THE SPANISH MEDIA AGENDA

As part of the implementation of the WPA's program ''Schizophrenia: Open the Doors'' in Spain, the team coordinating it, led by the author of this chapter, has followed the coverage of mental health issues in general, and schizophrenia in particular, in the Spanish press. This press coverage analysis was undertaken to allow the evaluation of the program's media campaign, and the detection of sources of stigmatization.

The Spanish press coverage started on November 1998 and continues at the time of going to press. Some of the observations made up to March 2001 seem to support the idea put forward in this chapter that the active participation of psychiatrists in media campaigns can improve the public perception of mental health issues and reduce the stigma associated with mental disorders.

In Spain, 35.4% of the population older than 14 years old, totaling 34.5 million persons, read the daily newspapers. These reading habits place Spain in the fifth place in the European Union regarding the levels of circulation of the print media. The leading country is Germany, followed by the UK and France.

The press coverage analysis covered a range of publications including all seven national general information dailies and their regional editions and supplements, 91 regional and local newspapers, and up to 151 magazines and other publications of all sectors and topics.

The objective of this analysis was to evaluate the effects of the media campaign designed as part of the ''Schizophrenia: Open the Doors'' implementation steps for Spain. In this program's action plan, according to the new strategic model developed, the media were to be used selectively and mainly as vehicles to reach the program's target audiences: patients, their relatives and the mental health professionals closest to the disorder.

Of course, the full results of this analysis focus on schizophrenia and how it is portrayed in Spanish media. Nevertheless, some of the more general conclusions can be used as an example of the prominence mental health is taking in the media agenda and how psychiatrists can positively influence the content of this information. Furthermore, the first signs of how this influence persists and affects later coverage are now, once the first phase of the media campaign is ending, starting to become apparent.

The high number of news articles about mental health published in the Spanish press during the period studied (November 1998–March 2001) is the first sign of the prominence of this topic: 2090 news items were compiled. Nevertheless, the impact of these information pieces might be small if they appeared in specialized publications or magazines with small circulation figures. In the case of mental health coverage during this period, this does not seem to be the case: 36.9% of the news items were published in regional newspapers and 30.5% in the national press.

The interest of media in these topics has been growing steadily in Spain: in the two whole years monitored (1999 and 2000), the increase in the number of articles was 30.6%. But not all topics have shown the same growth: in 2000, schizophrenia had become the most prominent topic, with a total of 271 articles, an increase of 52% over 1999. During the same period, a topic of general interest, depression, showed a decrease in coverage. The total number of articles about depression in 2000 was only 46% of the total coverage reached in 1999. The coverage of schizophrenia was even higher than the number of items dedicated to ''mental disorders'' in general (those articles about mental health issues in general, not relating to any particular illness), a topic that was covered by 261 news items in 2000.

This happened while the media campaign of the program ''Schizophrenia: Open the Doors'' was under way in Spain. This campaign consisted of a series of media briefings in 14 Spanish cities, during which psychiatrists involved in the program acted as spokespersons in the media. They presented the program, transmitting the campaign's key messages, such as the fact that 80% of people suffering from schizophrenia can overcome the disorder, the existence of new treatments and the advance they represent, and how the myths about the disorder help to stigmatize the people suffering from it. These press conferences, held between June and November 2000, generated directly a total of 81 news items, reaching a total audience of 8 209 375 people.

In order to guarantee the coherence of messages and facilitate the transmission to the media, the psychiatrists involved in the program had received media training with specific materials. The focus chosen to design these materials was in line with the way the media were to be approached. Since the program's objective was to feed through the media accurate

information in order to increase knowledge of schizophrenia among key target audiences, the materials to be handled and distributed to the media had to be basically informative, as had to be the role of the spokespersons.

This increase in positive coverage and the success of the activities designed to distribute the program's messages through the media cannot be evaluated alone, but must be compared with the opposite effect that stigmatizing information may have. Indeed, that sort of coverage exists and persists in the Spanish press. In 2000, 53 articles were published that had stigmatizing potential, mainly because they associated schizophrenia with violence or crime. This number was even higher than in 1999, when a total of 20 stigmatizing items were published; but while in 1999 the appearance of this information was balanced throughout the year (60% during the first semester, 40% during the second), the distribution was different in 2000. Between January and June 2000, 80% of the stigmatizing articles were published. During the second semester, coinciding with the development of the media campaign, only 11 (20% of the total) stigmatizing items appeared.

Indeed, one of the program's goals is to decrease or counteract this sort of coverage. But, realizing that this is a long-term objective, the Spanish implementation strategy implied that, even if this negative coverage persisted, an adequate positive coverage (that is, the publication of ''controlled'' information) would counteract this information. We seemed to see this happening when we compare the coverage of 1999 and that of 2000. These data also suggest that a higher number of positive articles can cause a decrease in the publication of stigmatizing news items, perhaps because at the same time that this controlled information flow is generating immediate coverage, it is also serving as a learning experience for the media. Journalists become more aware of the topic and of how to treat it, and this higher sensitivity brings lasting effects.

A selection of three news stories may illustrate this point (Figure 11.1). First of all, a typical story in which mental disorders are associated with criminal acts. On January 9, 1999, the national daily *La Razón* published a news story with the headline ''A schizophrenic patient attacks his doctor with sword and puts him in coma''. The story occupies one-third of a page and reports the crime in detail (why the doctor was at the patient's home, how he was taken to the hospital). There are no other references to schizophrenia but the ones that describe the subject, nor any other hypothesis of the person's motivation to commit the crime. Therefore, it seems that describing someone as ''schizophrenic'' was, for this newspaper, enough to explain the cause of a terrible incident.

The second example is from the news conference held in Cádiz, a city in southern Spain, on January 26, 2001. The spokesperson on this occasion was Prof. J.J. López-Ibor, Jr. The context of this conference is particularly rele-



Un paciente esquizofrénico le clava una espada a su médico y le deja en coma

La agresión se produjo en Tolva (Huesca) cuando la víctima fue a visitar al enfermo

El estado de Javier Lascorz es muy grave, se encuentra en estado de coma, entubado y con sedantes

Un médico muy apreciado

SANIDAD ◆ PRESENTÓ A LOS MEDIOS EN CÁDIZ EL PROGRAMA 'LA ESQUIZOFRENIA ABRE SUS PUERTAS'

Los menores que cometen asesinatos sufren "una patología social", afirma López Ibor

El prestigioso psiquiatra cree que los actos violentos se mimetizan del entorno social

Encuentro sobre Diálisis

Nuevas piezas para el 'puzzle' de la esquizofrenia

El hallazgo de los primeros genes aporta pistas para integrar los nuevos y dispersos descubrimientos

La doble personalidad y otros errores

El cerebro y todo lo demás

Figure 11.1 Three examples of press coverage before, during and after a media campaign. ''A schizophrenic patient attacks his doctor with a sword and puts him in a coma'' (*La Razón*, January 9, 1999; reproduced by permission of Jose A. Sentis, *La Razón*), '''Teenagers who commit murder suffer from social pathology,' says López-Ibor'' (*Cádiz, Información* January 27, 2001; permission applied for) and ''New pieces for the schizophrenia puzzle—double personality and other mistakes'' (*El País*, March 27, 2001; reproduced by permission of Gonzalo Casino Rubio)

vant, since some weeks before the presentation of the program to the local media, two teenagers had committed a murder in the area, generating much speculation in the media about the motivation of the murderers. Among those, mental disorders were often mentioned. At the press conference to introduce the WPA program, Prof. López-Ibor explained the difference between mental disorders and social pathologies, using this case as an example of how often people affected by schizophrenia are automatically classified as violent or potentially capable of committing acts of violence.

Obviously, linking the topic of the presentation to current events of general interest generated more attention to the program's contents. But this is also a good example of how a psychiatrist can become an authoritative and prestigious source of information. Especially when the news topic is liable to be treated in a sensational way, access to a prestigious professional who can provide an in-depth and objective angle to the information is fundamental to counteract ''tabloid style'' coverage. That this piece is from a regional daily (*Cádiz Información*) also illustrates how these topics usually obtain a wider coverage in local or regional media. Fortunately, these are, in fact, the kinds of media to which psychiatrists may have the easiest access.

Finally, here is an example of a longer-term effect of working with media selectively. In March 2001, *El País* (the leading Spanish national daily) devoted a whole page to schizophrenia. This article was announced in the paper's front page and was the main topic of the weekly health supplement of the publication (again, a general information daily, not a specialized publication addressing health professionals). Not only was such a large space devoted to explaining the latest scientific knowledge of the causes and origins of the disorder, but also a whole column focused on ''double personality and other mistakes'', reflecting one of the ''Schizophrenia: Open the Doors'' campaign's key messages. Among these are the confusion of schizophrenia with multiple personality disorder, the incorrect association with a higher degree of violence, and the antisocial character of people affected by the disorder. This article even referred to the way the press deals with the subject, pointing out examples of recently misused terms.

This article was not originally derived from a press conference or an interview by the program's spokespersons, and it was published months after the campaign was launched in Madrid (where *El País* is edited). It is, indeed, a good example of how ''media learn''. Strategically driven media activities do not only have an immediate effect (the information that is published immediately after the press conference, the interview or any other initiative) but also help journalists discover new topics and, basically, improve the quality of the coverage for issues arising afterwards.

In summary, it seems that the press is responsive and accessible to professional medical information about mental disorders and other mental

health topics. This is confirmed by the repercussions of the media campaign developed for the program ''Schizophrenia: Open the Doors'' in Spain. The media are willing to improve the quality of the information they transmit and to increase the space devoted to news articles. Information elaborated with a medical basis and by an authoritative source is much better received than that apparently partial or sensational. When these factors coincide, the press coverage becomes greater and better; the news element of the information is complemented with pictures, graphs and testimonials and, without any doubt, the topic also gains in frequency of reporting.

CONCLUSIONS

Psychiatrists should take the responsibility to build a positive perception of the field of psychiatry as a medical discipline. This responsibility has become inherent to the exercise of psychiatry, since the public image of mental health and mental health professionals is closely related to the ''therapeutic aspect'' of the discipline. Any contribution to the promotion of mental health as an integral part of well-being will have positive consequences for people suffering from mental disorders and their relatives, and will help mental health professionals exercise their professional activities better.

Mental health professionals should reconsider the importance of the media in today's society and should become more accessible to the media, not only individually but also as a group. They should become familiar with the way the media function in order to create and transmit a set of agreed basic messages.

In speaking of the position of the field of psychiatry, we are speaking not only of its position in terms of public image. The objective is to close the gap between this field and society in order to create a circular process by which information flows between the two. If the media and psychiatrists work together, they will be able to send controlled messages capable of generating greater interest in society and a change in attitude among the population. If the interest of the public increases regarding the topic of mental health, the consumption of the media that offers these contents will increase. This will create a natural tendency for the media to deal with these topics. Once public opinion breaks down the taboos that surround the field of psychiatry and grasps the important role it plays in society, psychiatrists will have improved their image and the flow of information will have increased, and society will become informed and rational about mental illness. As a result, the existing barriers will be overcome, because people will not have second thoughts about consulting a psychiatrist when they think that they are suffering from mental illness.

The appropriate method to create interest in the population about a given topic is by generating knowledge about that topic. If the topic is mental health, it is important not to confuse knowledge with presence. There are attitudes of stigma and discrimination in our society with respect to mental illnesses. Generating knowledge of mental illnesses in an uncontrolled manner through the media can provoke or increase discriminatory attitudes and behavior. Evidently, the high visibility of mental illnesses in the media can be just as ''helpful'' as ''harmful''. The best solution is to include information that is complete and detailed about mental illnesses, its causes, and its diagnosis and treatment.

There must be, of course, a coordinated effort by all parties involved in mental health. Good examples are the ''alert groups'' that have been formed to act against the stigma associated with mental illness. The role of these action groups, ''stigma clearinghouses'', is to watch closely for any stigmatizing information published or broadcast. When this happens, a response is sent immediately to the publisher or editor, not only asking for a correction but, most important, also informing the journalist of why that expression is incorrect and what consequences this kind of information can have on perpetuating the stigma.

Just as the psychiatrists do, the stigma clearinghouses also constitute a good source of information for journalists. Although journalists usually look for expert information when they approach a psychiatrist, when they approach persons involved in the clearinghouses they look for testimonies. They are a source of credibility, and because they are outside the medical discipline of psychiatry, they are perceived as reliable informants. They have no difficulty with the language because they use a simple terminology learned from their close contact with the psychiatrists.

In recent years, the profession has developed positive initiatives, such as including the relationship with the media among the topics of the plenary sessions at the 11th World Congress of Psychiatry (Hamburg, August 6–11, 1999). The author of this chapter participated in this session, which was entitled ''Psychiatry as Perceived by the Media—The Challenge''.

For its part, the American Psychiatric Association held in 1998 the first ''Consensus Conference'' that included psychiatrists and journalists. In this event, topics such as the informative treatment of mental health were dealt with. Other relevant topics, such as confidentiality or how to report alternative treatments, were also discussed.

The author also coordinated the workshop ''Psychiatrists and the Media'', held at the 5th European Psychiatric Congress (Prague, October 29–November 1, 2000). The objective was to provide participants with a better knowledge of the media and some tips to improve their relationship with media representatives. At this encounter, the participants expressed their concern about how to deal with the media when they request infor-

mation. Above all, they were concerned about the consequences of focusing their comments on one or another aspect of the profession—diagnosis as opposed to treatment, cure as opposed to stigmatization.

On the part of journalists, there are also initiatives that should be mentioned. Various press associations around the world have created health sections and specialized journalists have become associates of these sections. In the case of Spain, ANIS (Asociación Nacional de Informadores de la Salud) has become a very important piece in this puzzle. These professionals are aware that, just as journalists need to specialize in other fields, so they need to pay special attention to and work towards covering mental health issues with precision and rigor.

In any case, the common point of departure is the one treated in this volume. What is the social context of psychiatry and how does it influence all aspects of this medical specialty? When this social context perspective is enriched by the media point of view, and initiatives are carried out to improve the perception of mental health that the media convey to the public, the influence is immediate and positive. These effects include promotion of mental health in general, but also better perspectives on particular aspects such as diagnosis, treatment and social integration. With just some effort by both sides, the media and psychiatrists can form a mutually useful relationship that will benefit all those affected by a mental disorder, their relatives and anyone concerned with the field of mental health.

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